

Coagulation Patient Clinical History Form
To be completed for Thrombosis and Bleeding Workup

Forward this form directly to: HMC Special Coagulation Lab
325 9th Ave, GWH-47, Box 359743
Seattle, WA 98104
Phone 206-744-2621 Fax: 206-744-8654

Patient Name (Last, First): _____ Date of Birth: _____
Referring Medical History No: _____
Referring Physician: _____ Physician's phone#: _____
Is patient pregnant: No Yes (Due date: _____)
Pertinent Family History: _____

Reason for Testing: Venous Thrombosis (Date of last thrombosis event: _____)
 Arterial Thrombosis
 Bleeding
 Therapeutic Drug Monitoring
 Anti-Phospholipid Syndrome
 Other, please specify: _____

Has patient taken any anticoagulants in the past 7 days? No Yes (Last dose on _____)
Please check box if patient is taking any of the following:
 Coumadin (Warfarin)
 Heparin, unfractionated Low molecular weight Heparin Fondaparinux
 Direct thrombin inhibitor [Pradaxa (Dabigatran), Acova (Argatroban), Angiomax (Bivalirudin)]
 Direct Xa inhibitor [Xarelto (rivaroxaban), Eliquis (Apixaban), Savaysa (Edoxaban)]
 Anti-platelet drugs (NSAIDS, Aspirin, Clopidogrel, Prasugrel, Abciximab, etc.)
 Emicizumab (Hemlibra)
 Other _____

Completion of the above information will assist us in reflexive testing pathway selection and interpretation of the results.