

Special Coagulation Testing Requisition Thrombosis Investigations

For detailed testing information, refer to
APL Test Directory (<http://ahsweb.ca/lab/apl-td-lab-test-directory>)

Scanning Label or Accession # *(lab only)*

Patient	PHN		Date of Birth <i>(dd-Mon-yyyy)</i>			
	Expiry: _____					
	Legal Last Name		Legal First Name		Middle Name	
	Alternate Identifier		Preferred Name		Phone	
		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary <input type="checkbox"/> Prefer not to disclose				
Address			City/Town		Prov	
					Postal Code	
Provider(s)	Authorizing Provider Name <i>(last, first, middle)</i>			Copy to Name <i>(last, first, middle)</i>		Copy to Name <i>(last, first, middle)</i>
	Address			Phone		Address
	CC Provider ID	CC Submitter ID	Legacy ID	Phone		Phone
	Clinic Name			Clinic Name		Clinic Name
Collection	Date <i>(dd-Mon-yyyy)</i>		Time <i>(24 hr)</i>		Location	
					Collector ID	
DO NOT USE THIS REQUISITION FOR ROUTINE COAGULATION STUDIES (INR, PTT, FIBRINOGEN OR ANTI -XA) OR ANTIPHOSPHOLIPID ANTIBODY/LUPUS WORKUP OR ADVANCED PLATELET STUDIES. TESTING WILL BE CANCELLED IF REQUISITION IS INCOMPLETE						
Answer all 3 questions	Is the patient currently on any anticoagulants? <i>(Select all that apply)</i> <input type="checkbox"/> None <input type="checkbox"/> Heparin <i>(unfractionated or low-molecular)</i> <input type="checkbox"/> Vitamin K Antagonist <i>(eg. warfarin)</i> <input type="checkbox"/> Other <i>(eg. apixaban, rivaroxaban, fondaparinux, dabigatran, etc)</i> _____					
	Is the patient currently pregnant or post-partum? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	Is the patient on any estrogen containing medication <i>(including birth control)</i>? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Answer questions in order	Are you a member of Thrombosis Medicine, High-Risk Pregnancy, Pediatric Hematology or Clinical Genetics Specialty Groups? <input type="checkbox"/> Yes ► Proceed to "Test(s) Requested" <input type="checkbox"/> No ► Proceed to next question					
	Has a member of the above specialty groups recommended testing? <input type="checkbox"/> Yes ► Name of Consultant _____ Proceed to "Test(s) Requested" <input type="checkbox"/> No ► Proceed to next question					
	Has there been an acute thrombotic episode within the last 3 months? <input type="checkbox"/> Yes ► Testing NOT required; requested tests will be auto-cancelled <input type="checkbox"/> No ► Proceed to next question					
	Is there a previously positive thrombophilia test that requires confirmatory testing? <input type="checkbox"/> Yes ► Describe _____ Proceed to "Test(s) Requested" <input type="checkbox"/> No ► Proceed to next question					
	Does a first-degree relative have a known inherited thrombophilia and patient is considering pregnancy or hormone use? <input type="checkbox"/> Yes ► Describe _____ Proceed to "Test(s) Requested" <input type="checkbox"/> No ► Proceed to next question					
	Is testing ordered because of pregnancy loss or pregnancy complications? <input type="checkbox"/> Yes ► Testing NOT required; requested tests will be auto-cancelled <input type="checkbox"/> No ► Proceed to next question					
	Is patient <50 years with history of unprovoked (no preceding surgery, trauma or prolonged immobility) venous thrombosis OR had at least one venous thrombosis at an unusual site (not including unilateral leg DVT, superficial or retinal thrombosis)? If Yes <i>(to one or both)</i> : Proceed to "Test(s) Requested" If No : Testing NOT required; requested test(s) will be auto-cancelled.					
	Test(s) Requested <input type="checkbox"/> Factor V Leiden <input type="checkbox"/> Prothrombin 20210 <input type="checkbox"/> Protein C <input type="checkbox"/> Protein S <input type="checkbox"/> Antithrombin <input type="checkbox"/> Antiphospholipid Syndrome Investigation <i>(includes lupus anticoagulant, anti-cardiolipin antibody and anti-beta-2-glycoprotein antibody tests)</i>					