COAGULOPATHY WORK-UP
PATIENT QUESTIONNAIRE

FAX Completed Forms to: (918) 744-2885

Patient Name: ______________________________

Date of Birth: ______________ **Sex:** _____ **MRN#:** ______________

Diagnosis: ______________________________

Ordering Physician: ______________ **Physician Phone#:** ______________

PATIENT HISTORY

YES	NO	
☐	☐	**Are you Fasting?**

YES	NO	Have you ever had any of the following:
☐	☐	Have you ever had a Blood Clot?
☐	☐	A Heart Attack (MI)?
☐	☐	A Stroke?

YES	NO	Are you now taking:
☐	☐	Coumadin?
☐	☐	Heparin?
☐	☐	Xarelto?
☐	☐	Eliquis?
☐	☐	Pradaxa?
☐	☐	Savaysa?
☐	☐	Other anticoagulant (Blood Thinner)?
		If so, please list:

Please attach this form to RML requisition or fax it to the above number