



National Reference Laboratory : Sector 18, Block E, Rohini, New Delhi 110 085

Tel: 91-11- 3040 3210, 3988 5050. Fax: 91-11-3040 3204

E-mail: lalpathlabs@lalpathlabs.com Website: www.lalpathlabs.com

**COAGULATION REQUISITION FORM**

Lab No.: .....

Date : .....

Type of specimen :  Fasting  Non-fasting

Time of specimen Collection: .....

Name : ..... Age : ..... Sex:  Male  Female

Tel No. : 1. Patient ..... 2. Physician : .....

**Clinical History :****A. Bleeding Disorder :**I. Congenital :  Yes  NoII. Acquired  Yes  No**B. Thrombotic Disorder**I. Congenital :  Yes  NoII. Acquired  Yes  No**C. History of blood transfusion / blood products** Yes  No

If yes, when : .....

**History of Laboratory investigations:**1. Prothrombin Time:  Yes  No Date  
If yes : Last value of INR: .....2. APTT  Yes  No  
If yes : Last value: .....3. Liver function test, if performed  Normal  Abnormal .....

4. Others, specify: .....

**History of Drug / Medication, if any, for Coagulation Disorder:**

		Current dose	Date of last change in dose
A. Oral Anticoagulant	<input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....
(i) Warfarin / Acetrom :	<input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....
(ii) Hirudin :	<input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....
(iii) Coumarin:	<input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....
(iv) Others, specify:	.....		
B. I.V. infusion:			
(i) Low Molecular weight Heparin:	<input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....
(ii) Unfractionated heparin:	<input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....
C. History of major surgery (e.g. Cardiac / Neurosurgery) in last one year	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Probable Diagnosis .....

Sample collected by : .....

Name of Collection centre .....