

Check:  Routine  Pre-surg. date: \_\_\_\_\_  Fax or Call Result

Patient Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_ Date of Test: \_\_\_\_\_

SSN# \_\_\_\_\_ DOB: \_\_\_\_\_ Sex:  M  F Physician Signature \_\_\_\_\_

Instructions to the patient:

Medicare will only pay for tests that meet the Medicare coverage criteria and are reasonable and necessary to treat or diagnose an individual patient, see Section 1862 (a) 1 (A) of the Social Security Act.

If you have ordered any test in red or if you have checked any panels as a "screen", the patient may have to sign an Advance Beneficiary Notice.

\*Please check stability in Lab Test Handbook or call lab for specific instructions.

AN APPROPRIATE DIAGNOSIS ICD-9 CODE IS REQUIRED FOR EACH TEST ORDERED.

TESTS	ICD-9	TESTS	ICD-9
<input type="checkbox"/> (59328) Fetal Demise		<input type="checkbox"/> (59337) Hypercoag with meds	
<input type="checkbox"/> (59330) *Lupus Anticoag w/o Meds		<input type="checkbox"/> (51235) Thrombotic Risk Pre-preg	
<input type="checkbox"/> (59331) *Lupus Anticoag with Meds		<input type="checkbox"/> (51236) Thrombotic Risk During Pregnancy	
<b>*Call 5188 prior to blood draw</b>		<input type="checkbox"/> (51013) Hypercoag w/o meds	
<input type="checkbox"/> (51012) *Bleeding Profile, Abn Screen		<b>*Call 5188 prior to blood draw</b>	
		<input type="checkbox"/> (59338) *von Willebrand Profile	

MEDICAL HISTORY (Required for Interpretive Report)

PATIENT HISTORY	New Onset or Past Event	Family History (relationship)	PATIENT HISTORY
<b>Bleeding:</b>			<b>Predisposing Condition(s):</b>
<input type="checkbox"/> Easy Bruising			<input type="checkbox"/> Immobility, Trauma, Surgery (Specify)
<input type="checkbox"/> Spontaneous/Nontraumatic bruising >5 (2 in.)			<input type="checkbox"/> Autoimmune Disease
<input type="checkbox"/> Bleeding After Dental Procedure			<input type="checkbox"/> Malignancy
<input type="checkbox"/> Menorrhagia			<input type="checkbox"/> Myeloproliferative Disease
<input type="checkbox"/> Skin Petechiae			<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Hematuria			<input type="checkbox"/> Renal Disease
<input type="checkbox"/> Spontaneous Soft Tissue Hematoma			<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Post-Operative Bleeding			<input type="checkbox"/> Varicose Veins or Phlebitis
<input type="checkbox"/> Spontaneous Hemarthrosis			<input type="checkbox"/> Congestive Heart Failure
<input type="checkbox"/> Other			<input type="checkbox"/> Obesity
<b>Thrombotic Events:</b>			<input type="checkbox"/> Tobacco Use
<input type="checkbox"/> Deep Vein Thrombosis			<input type="checkbox"/> Oral Contraceptives or HRT
<input type="checkbox"/> Pulmonary Emboli			
<input type="checkbox"/> Myocardial Infarction			
<input type="checkbox"/> Stroke			
<input type="checkbox"/> Spontaneous Abortion			
<input type="checkbox"/> Other			
<b>ADDITIONAL HISTORY PERTINENT TO THE PATIENT</b>			
			PHYSICIAN SIGNATURE _____
			DATE _____

Anticoagulant (circle):  
None    Coumadin  
Heparin (UFH or LMWH)

Record all medications taken in the past 10 days (prescription and nonprescription). Include aspirin, NSAIDs, antibiotics, estrogen, and OTCs.

Medications:    Dose:    Last Taken:



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Special Coagulation Panels

PATIENT LABEL  
OR

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

MR #: \_\_\_\_\_