

Requesting Health Care Provider Name: Address:	Patient Information (as per OHIP card) Last Name: First, Middle Name:			
Phone Number: Billing Number:	DOB:	F		
Copy-To Health Care Provider Name: Address:	Address: Phone Numbe	er:		
Billing Number:	HCN:		Version:	
THROMBOSIS DISORDERS				
THOMBOSIS DISONDENS		Anticoagulant Drugs		
Is the patient on an anticoagulant? YES / NO		DOACs Apixaban	Heparins Dalteparin	VKA
If yes, indicate name of anticoagulant:		Dabigatran Edoxaban Rivaroxaban	 Enoxaparin Tinzaparin Unfractionated heparin 	Warfarin
1. Inherited Thrombophilia Assays			'	
Natural anticoagulant assays Antithrombin Protein C Activity Free Protein S Molecular Thrombophilia assays Factor V Leiden Prothrombin Gene Mutation	anticoag Results a	ulants (apixaban, dab are <u>not interpretable.</u> plecular thrombophili	warfarin, heparin, or dir Digatran, edoxaban, riva a assays <u>can be tested</u> v	roxaban).
Inherited thrombophilia assays are <u>not</u> indicated for most patien They are <u>not</u> indicated for arterial thrombosis. To assess if testin				
2. Anti-phospholipid Antibody Panel ☐ Lupus anticoagulant	DO NOT TEST lupus anticoagulant if patient is on anticoagulants, especially direct oral anticoagulants (apixaban, dabigatran, edoxaban, rivaroxaban). Results are not interpretable.			
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☐ Anti-cardiolipin IgG Antibody☐ Beta-2-Glycoprotein-1 Antibody	If LA testing must be done on anticoagulants:			
	 Obtain sample ≥12hrs from last dose of LMWH Obtain sample ≥48hrs from last dose of DOAC 			

For Inquires, contact LifeLabs Customer Care Centre 1-877-849-3637