A5_148 x 210 mm

Pathkind Labs

Affix Barcode

COAGULATION HISTORY FORM

Name of the Patient: .....

Name of the Collection Center/Lab: .....

Date of Sampling: ..... Age/Sex: .....

Type of Specimen: Fasting ☐ Non Fasting ☐

History of Drug

Warfarin/Acitrom Yes ☐ No ☐ If Yes Current Dose : .....

Others, please Specify: .....

History of Lab Investigation

Prothrombin Time Yes ☐ No ☐ If Yes last Value & Date of Testing : .....

APTT Yes ☐ No ☐ If Yes last Value & Date of Testing : .....

Others, please Specify: .....

Dated Signature of Patient: .....