

# Hemostasis Requisition

## ACCOUNT INFORMATION

Client Name/Account Number:	
Client Address:	
City/State/Zip:	
Client Phone:	Client FAX:

2110 Research Row, Suite 221  
Dallas, Texas 75235  
Lab: 214-645-5067  
FAX: 214-645-5057  
Customer Service: 214-645-7057  
Toll Free: 877-887-8136  
CLIA #45D-0659587, CAP #2723201



VERIPATH LABORATORIES

www.veripathlabs.com

## REQUIRED ORDER INFORMATION

<b>BILL TO:</b>	<input type="checkbox"/> Facility / Client <input type="checkbox"/> Patient / 3rd party – Billing information must be provided	
Patient Name: (Last, First, Middle)		
Mother's Name: (if infant)		
Date of Birth:	Sex:	Patient ID / MR#:
Hospital Inpatient Y / N	Collection Date:	Collection Time: AM : PM
Ordering Physician:	NPI:	
Phone:	Pager:	FAX:
Clinical Indication for Tests Ordered:		

## PATIENT/3RD PARTY BILLING INFORMATION

<b>ICD-9 Code(s)</b>	<input type="checkbox"/> Signed ABN included
<b>Medicare patients with non-covered diagnoses must sign Advanced Beneficiary Notice (ABN) on reverse side.</b>	
ICD-9 Codes applicable to each and every test requested should come only from the ordering physician, represent the reason for the test order at the time of order, and be supported by the patient's medical record. Physicians should order only tests that are medically necessary for the diagnosis or treatment of the patient. Tests ordered should be single laboratory tests appropriate for the patient's medical condition. Tests for screening purposes may be ordered, but may not be reimbursed.	
Insured/Responsible Party Name: (if different from patient-Last, First, Middle)	Date of Birth:
Patient's relationship: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	Responsible Party Address: (street, city, State, zip)
Sex:	Phone:
Employer's Name:	Employer's Phone:
Insurance Co. Name:	Insurance Co. Phone:
Insurance Co. Address:	
Policy #:	Group #:
<input type="checkbox"/> Medicare <input type="checkbox"/> HMO <input type="checkbox"/> Other <input type="checkbox"/> Medicaid <input type="checkbox"/> PPO	Member ID#:
Referral Authorization/Precertification #:	
Name:	Date/Time:

## SPECIMEN INFORMATION

<input type="checkbox"/> Red top	<input type="checkbox"/> Sodium citrate tube (blue top)	<input type="checkbox"/> EDTA tube (purple top)
<input type="checkbox"/> Frozen Plasma	<input type="checkbox"/> Frozen Serum	
Past History: <input type="checkbox"/> Bleeding <input type="checkbox"/> Stroke <input type="checkbox"/> MI <input type="checkbox"/> PE/DVT <input type="checkbox"/> Malignancy <input type="checkbox"/> Recurrent Pregnancy Loss		
Drug History: <input type="checkbox"/> Heparin <input type="checkbox"/> Coumadin <input type="checkbox"/> Aspirin <input type="checkbox"/> Plavix <input type="checkbox"/> Other: _____		
Family History: <input type="checkbox"/> Bleeding <input type="checkbox"/> Thrombosis <input type="checkbox"/> Other: _____		
Recent Transfusion History: <input type="checkbox"/> FFP <input type="checkbox"/> Platelets <input type="checkbox"/> Cryoprecipitate (past 2 weeks)		

## TESTS REQUESTED

### SCREENING COAGULATION TESTS

- PT/INR
- APTT
- Fibrinogen
- Thrombin Time
- D-Dimer Quantitative
- PFA-100<sup>TM 3</sup>

### SUGGESTED PROFILES<sup>3</sup>

- Investigation of Prolonged APTT (history of bleeding)
- Investigation of Prolonged APTT (no history of bleeding)
- Investigation of Prolonged PT
- Investigation of Prolonged PT and APTT
- Antiphospholipid Syndrome
- Circulating Inhibitor (no history of bleeding)
- Circulating Inhibitor (history of bleeding)
- D.I.C.
- Dysfibrinogenemia
- Hemophilia A or B (known diagnosis)
- Hypercoagulable Comprehensive
- Pregnancy Loss
- von Willebrand Disease Diagnostic
- von Willebrand Disease Sub-Classification

### BLEEDING DISORDER TESTS

- Alpha-2-Antiplasmin
- Factor II Activity<sup>1</sup>
- Factor V Activity
- Factor VII Activity<sup>1</sup>
- Factor VIII Activity
- Factor VIII Activity (Refacto®)
- Factor IX Activity<sup>1</sup>
- Factor X Activity<sup>1</sup>
- Factor XI Activity

### BLEEDING DISORDER TESTS cont'd

- Factor XIII Activity (5M Urea)
- Reptilase Time
- Thrombin Time<sup>2</sup>
- von Willebrand Factor Antigen
- von Willebrand Factor Assay (Ristocetin Co-factor)
- Collagen Binding Assay (CBA)
- Ristocetin Induced Platelet Agglutination<sup>3</sup>  
Requires Prior Laboratory Scheduling 214-645-5067
- von Willebrand Factor Multimers
- Plasminogen Activator Inhibitor-I (PAI-1)

### HYPERCOAGULABILITY TESTS

#### Natural Anticoagulants

- Activated Protein C Resistance<sup>3</sup>
- Antithrombin Activity<sup>1,2</sup>
- Antithrombin Antigen
- Protein C Activity<sup>1</sup>
- Protein C Antigen<sup>1</sup>
- Protein S Activity<sup>1</sup>
- Protein S Antigen<sup>1</sup> (Total and Free)

#### Antiphospholipid Antibody (Ab) Tests

- Anticardiolipin Ab (IgG, IgM, IgA)
- Antiphosphatidylserine Ab (IgG, IgM, IgA)
- Anti-β<sub>2</sub>-Glycoprotein 1 (IgG, IgM, IgA)
- Antiprothrombin Ab (IgG, IgM)
- Lupus Anticoagulant<sup>3</sup>  
Includes dRVVT and PTT-LA; with reflex to Hexagonal PL Neutralization Procedure

#### Molecular Testing

- Factor V Leiden Mutation
- Prothrombin G20210A Mutation
- MTHFR (Methylentetra hydrofolate reductase) (C677T & A1298C mutations)

### Other Hypercoagulability tests

- Heparin Induced Thrombocytopenia (HIT) Ab<sup>3</sup>
- Factor VIII Activity
- Factor XII Activity
- Homocysteine level
- Plasminogen
- Plasminogen Activator Inhibitor-1 (PAI-1)
- Fibrinogen, Immunologic
- Reptilase Time

### CIRCULATING INHIBITORS<sup>3</sup>

- Factor \_\_\_ Inhibitor (Antibody) Screen (R)
- Factor VIII Inhibitor (Antibody) Assay
- Factor IX Inhibitor (Antibody) Assay
- PTT Mixing Study<sup>3</sup>
- PT Mixing Study<sup>3</sup>

### ANTICOAGULANT THERAPY MONITORING

- Heparin Anti-Xa Assay, Unfractionated
- Heparin Anti-Xa Assay, LMW Type: \_\_\_\_\_
- Factor X Assay (Chromogenic)
- Arixtra (Fondaparinux) by anti-Xa assay

### TESTS REQUIRING PRIOR LABORATORY SCHEDULING<sup>3</sup> 214-645-5067

- Hyperactive Platelet Studies (sticky platelets)
- Platelet Aggregation, Whole Blood
  - Bleeding tendency
  - Aspirin non-responsiveness
  - Plavix non-responsiveness

<sup>1</sup>Results may be affected by Coumadin.

Should be off for at least 2 weeks

<sup>2</sup>Results may be affected by Heparin.

<sup>3</sup>With Interpretation

<b>VERIPATH USE ONLY</b>	<b>Transport Container:</b> ___ Yellow ___ Green ___ Purple ___ Syringe ___ Conical ___ Red ___ Blue ___ Cup ___ Trans Tube ___ Block ___ Slides ___ Formalin ___ Other:	<b>Total # of specimens:</b> _____	<b>Transport Conditions:</b> <input type="checkbox"/> Frozen <input type="checkbox"/> Slushy <input type="checkbox"/> Refrig <input type="checkbox"/> Room Temp	<b>Destination:</b> <input type="checkbox"/> Other _____ <input type="checkbox"/> Aston <input type="checkbox"/> Coag <input type="checkbox"/> Cytogen <input type="checkbox"/> Flow <input type="checkbox"/> Hist <input type="checkbox"/> Mol Dx <input type="checkbox"/> OncoDx	<b>Initials:</b> _____
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(A) Notifier(s):

(B) Patient Name:

(C) Identification Number:

### ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

**NOTE:** If Medicare doesn't pay for (D) \_\_\_\_\_ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the (D) \_\_\_\_\_ below.

(D) _____	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:

#### WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the (D) \_\_\_\_\_ listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

#### (G) OPTIONS: Check only one box. We cannot choose a box for you.

**OPTION 1.** I want the (D) \_\_\_\_\_ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

**OPTION 2.** I want the (D) \_\_\_\_\_ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

**OPTION 3.** I don't want the (D) \_\_\_\_\_ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

#### (H) Additional Information:

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature:

(J) Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.