Special Coagulation Anticoagulant Drug List

**SCAN COMPLETED FORM TO CCLSpecialCoagulation@compunetlab.com
OR FAX TO 937-641-2677
***PLACE ORIGINAL COPIES OF ALL PAPERWORK IN BAG WITH SPECIMEN(S)

Date: _____

Patient Name: _____ Patient Date of Birth: _____

Below circle either: *Not on any Anticoagulant Medication* or ***any medication taken indicating last dose date*.**

Brand Name (Generic)	Date of last dose
Coumadin (Warfarin)	_____
Unfractionated Heparin (UF Heparin)	_____
Lovenox (Enoxaparin)	_____
Fragmin (Dalteparin)	_____
Arixtra (Fondaparinux)	_____
Xarelto (Rivaroxaban)	_____
Pradaxa (Dabigatran)	_____
Eliquis (Apixaban)	_____
Argatroban	_____
Savaysa (Edoxaban)	_____
Activase (Alteplase)	_____
Angiomax (Bivalirudin)	_____

Not on any Anticoagulant Medication

Completed by: Patient

RRL staff member name: _____

PSC staff member name: _____

Office staff member name _____

Processing Department:
Forward a copy to Special Coagulation Department.
Image original.