

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) _____

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.