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| **All sections of this form MUST be completed by the requesting medical team. Samples will not be analysed unless a fully completed form accompanies the samples.** Thrombophilia Testing includes any/all of the following assays: Antithrombin, Protein C, Protein S, Factor VIII, Fibrinogen, Activated Protein C Resistance (APCR), Genetic test for the Factor V Leiden gene mutation and/or the Prothrombin gene mutation *(written patient consent is required for these genetic tests – see below)* and/or Lupus Anticoagulant (LA) screen.  ***Thrombophilia screen: 6 Coagulation samples and 1 EDTA (FBC) sample. LA Screen only: 4 Coagulation samples.***  ***For Lupus Anticoagulant requests, a separate serum sample should be sent with a separate request form to the Immunology Department for Cardiolipin and β2 Glycoprotein1 antibody testing*** |

**Section A: Patient Details**

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| **Surname Male Female**    **First Name Date of Birth**  **Medical Record Number: Ward**  **Hospital: Consultant**  **External Lab order number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date and time sample taken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sample type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Requested by (print name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Section B: Indication for testing: Thrombophilia Screen / Lupus Anticoagulant Screen**

*Refer to the guidelines for Thrombophilia Testing at* [*https://www.stjames.ie/LabMedInformation/*](https://www.stjames.ie/LabMedInformation/) *prior to sending request. This form can be downloaded at https://www.stjames.ie/services/laboratorymedicinelabmed/*

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| **Indication for testing: tick as appropriate and include specific details in the box below** | | | |
| **Thrombophilia screen** |  | **Thrombophilia testing in pregnancy** |  |
| Asymptomatic relatives with a family history of Antithrombin, Protein C or Protein S deficiency AND a family history of thrombosis |  | Woman with a history of unprovoked VTE (not on long term anticoagulation) **(LA screen only)** |  |
| First venous thrombosis in a patient with a family history of unprovoked or recurrent venous thrombosis in one or more first degree relatives |  | Woman with second trimester miscarriage |  |
| Asymptomatic relative of venous thrombosis patients with a known heritable thrombophilia prior to hormonal treatment |  | Family history of unprovoked or oestrogen provoked VTE in a first degree relative <50yrs |  |
| Other thrombosis (e.g. cerebral venous sinus, splanchnic vein thrombosis, skin necrosis secondary to vitamin K antagonists) |  | Woman with prior VTE and a family history of VTE and known Antithrombin deficiency or where the specific thrombophilia has not been detected **(Antithrombin level)** |  |
|  |  | Woman with a previous event due to minor provoking factor |  |
| **Lupus Anticoagulant screen only (a serum sample should be sent with a separate request form**  **to the Immunology Department for Cardiolipin and β2 Glycoprotein1 antibody testing)** | | | |
| Recurrent (≥ 3) first trimester consecutive miscarriages |  | Patient with unprovoked PE or proximal DVT if anticoagulation is discontinued |  |
| ≥ 1 unexplained death of a morphologically normal foetus at or beyond 10/40 |  | History of immune disorders and venous or arterial thrombosis |  |
| ≥ 1 premature birth of a morphologically normal neonate before 34/40 because of eclampsia / severe pre-eclampsia or placental insufficiency |  | Unusual or extensive venous or arterial thrombosis |  |
| Young adult (<50yrs) with ischaemic stroke |  | Diagnostic workup for Systemic Lupus Erythematosus, Rheumatology / Dermatology / Immunology services |  |
| **Include specific clinical details relating to this request for thrombophilia screen / LA screen. If the request is as a result of pregnancy loss, give details regarding the number and timing of pregnancy loss, number of months post pregnancy loss or post-partum. Testing should not be carried out while patient is on anticoagulant therapy.** | | | |

**Section C: Consent for genetic testing**

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| **The requesting clinician confirms that written consent has been obtained for testing for the Factor V Leiden mutation (if APCR test abnormal), testing for the prothrombin gene and subsequent storage of DNA samples Yes ☐ No ☐**  **The consent form should be kept locally in the patient record and SHOULD NOT be sent to the laboratory with the test request.** |