Haematology and Coagulation Laboratory, Cork University Hospital, Wilton, Cork. T12DC4A
Tel.: 021 4921350.

THROMBOPHILIA SCREEN/ ANTIPHOSHOLIPID ANTIBODY SCREEN REQUEST FORM

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.

Testing not performed if a patient is on anticoagulant therapy as results may be inaccurate.

Thrombophilia Testing includes any/all of the following assays: Antithrombin, Protein C, Protein S, 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 Antiphospholipid (Lupus) antibody testing.

Thrombophilia screen: 3 Coagulation (sodium citrate) samples, 1 EDTA sample and 1 serum (clotted) sample

Antiphospholipid (Lupus) Antibody screen and B2 glycoprotein only: 2 Coagulation (sodium citrate) samples and 1 serum (clotted) sample

Section A: Patient Details

Surname ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **Male** ☐ **Female** ☐

First Name ☐☐☐☐☐☐☐☐☐☐☐☐ **Date of Birth** ☐☐ ☐☐ ☐☐

Address _____

Medical Record Number: **Location/Hospital:**

Consultant/GP:_____ **Date and Time Sample Taken:** ___/_____/_____ _____:_____

Requested by (print name): _____ **Signed:**_____

LAB USE ONLY: SAMPLES REC'D **Clot Checked** ☐ **MS:**

Section B: Indication for testing: Thrombophilia Screen / Antiphospholipid Antibody Screen

*For **Guidelines**, **Request Forms and Consent Forms** on testing for inherited and acquired Thrombophilia in Cork University HospitalRefer to http://www.cuh.hse.ie/Our-Services/Our-Specialities-A-Z-/Laboratory-Medicine/Publications-Downloads*

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.		Women with a history of an unprovoked VTE (not on long-term anticoagulation) (antiphospholipid antibodies only).	
First venous thrombosis in a patient with a family history of unprovoked or recurrent venous thrombosis in a first degree relatives		Women with prior VTE and a family history of VTE and known Antithrombin deficiency or where the specific thrombophilia has not been detected should be tested for Antithrombin deficiency.	
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)		Women with second trimester miscarriage.	
		Women with a previous event due to a minor provoking factor.	
Antiphospholipid antibody testing (Lupus Anticoagulant and/or Anticardiolipin/B2GP1)			
Recurrent (≥ 3) first trimester consecutive miscarriages		Unusual or extensive venous or arterial thrombosis	
≥ 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		As part of diagnostic work-up for Systemic Lupus Erythematosus specialist care services e.g. Rheumatology, Dermatology	
Young adult (<50yrs) with ischaemic stroke		Patient with unprovoked PE or proximal DVT if anticoagulation is discontinued.	

Include specific clinical details relating to this request for thrombophilia screen. Antiphospholipid antibody 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.

Section C: Consent for genetic testing

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 Eluate 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.

A) Patient Details

Surname ……..…….... Forename ……..…….

Hospital ……..…….……..… Hospital Number …….……..

Date of Birth ……...

B) Collection and usage of samples

I ……..…….. (Print name) give consent for a blood sample to be taken from

……..…… (Myself or name of child) and the genetic material extracted, stored and tested for

……..…….. (Specify disorder).

Please initial the boxes below to indicate your consent

❑ The purposes for obtaining this sample and the potential implications have been explained to me and I have had an opportunity to have my questions answered.

❑ I have read and understood the information about genetic testing.

❑ It is the intention to store the sample for a maximum two year period.

❑ I understand that it may be necessary to use part of the sample anonymously for example for quality assurance or development of new tests.

Signed ……..…. Date……..
(Patient/parent/legal guardian – delete as appropriate)

C) Use and availability of results

❑ I hereby give consent for clinical and genetic information that may be relevant to other family members to be made available to relevant health care professionals.

❑ I agree to the results being entered into local or national confidential databases.

Signed ……..…. Date……..
(Patient/parent/legal guardian – delete as appropriate)

D) Person obtaining consent

I have explained to the above patient/parent/legal guardian the purpose of obtaining a sample for genetic studies and their implications.

Signed …….……..... Date……..…..

Print Name …….……. Position……..……..

Do not send this form to the Laboratory. A photocopy of the completed from should be given to the patient, the original filed in the patient's case notes and a copy filed in the family genetic record file.