

HYPERCOAGULABLE DISORDER



CLIENT NAME: _____
Submit the Client Information Questionnaire with this form

1. Please give the diagnosis: _____

2. Please note type of treatment:

Coumadin Hospitalization (date) _____
 Aspirin Heparin

3. Was there a thromboembolic event?

MI DVT Other
 CVA PE None

4. Has there been any evidence of recurrence?

Yes; please give details _____
 No

5. Is your client on any medications? (accurate name, dosage, and reason)

6. Does your client have any other health problems? (additional questionnaires may be required)