ALBERTA PRECISION LABORATORIES
Leaders in Laboratory Medicine

Antiphospholipid Syndrome Investigation Requisition

For detailed testing information, refer to
APL Test Directory (http://ahsweb.ca/lab/apl-td-lab-test-directory)

Scanning Label or Accession # *(lab only)*

Patient

PHN Expiry: _____		Date of Birth *(dd-Mon-yyyy)*		
Legal Last Name		Legal First Name	Middle Name	
Alternate Identifier	Preferred Name	☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to disclose	Phone	
Address		City/Town	Prov	Postal Code

Provider(s)

Authorizing Provider Name *(last, first, middle)*			Copy to Name *(last, first, middle)*	Copy to Name *(last, first, middle)*
Address		Phone	Address	Address
CC Provider ID	CC Submitter ID	Legacy ID	Phone	Phone
Clinic Name			Clinic Name	Clinic Name

Collection

Date *(dd-Mon-yyyy)*	Time *(24 hr)*	Location	Collector ID

Please use this requisition only for Lupus anticoagulant / Antiphospholipid Syndrome Investigation. If other special coagulation testing is required please use the appropriate Hemostasis or Thrombosis Investigations requisition.

Answer all questions

Is the patient currently on any anticoagulants? *(Select all that apply)*

☐ None ☐ Heparin *(unfractionated or low-molecular)* ☐ Vitamin K Antagonist *(eg. warfarin)*

☐ Other *(eg. apixaban, rivaroxaban, fondaparinux, dabigatran, etc)* _____

Reason for testing: *(select all that apply)*

☐ Thromboembolism

☐ Autoimmune Disorder

☐ Fertility Investigation

☐ Pregnancy Loss

☐ Prolonged PTT

☐ Other _____

Test(s) Requested

☐ Lupus Anticoagulant

☐ Anti-cardiolipin Antibody

☐ Anti-beta-2-glycoprotein Antibody