ARUP LABORATORIES

THIS IS NOT A TEST REQUEST FORM.
The information below is required to perform warfarin sensitivity genotyping.
Please fill out this form and submit it with the test request form or electronic packing list.

PATIENT HISTORY FOR WARFARIN SENSITIVITY GENOTYPING (*CYP2C9* & *VKORC1*)

Patient Name ____ **Date of Birth** ____/____/___ **Gender [ ] F [ ] M**

Ordering Physician ___________________________________ **Physician Phone (______)** __________________

Clinical Pharmacist/Dosing Specialist Name ____

Pharmacist Phone (   ) _______________________________

The Warfarin Genotyping Plus test (ARUP test code 2004358) generates a customized report providing the clinician with estimated daily and weekly maintenance doses of warfarin, as well as three warfarin initiation strategies for the first week of therapy. These dosing guidelines are personalized to the individual patient.

The following patient information is REQUIRED for dose calculations.

Patient Height __________________ in inches

Patient Weight _________________ in pounds

INR Target [ ] 2.0 [ ] 2.5 [ ] 3.0

Nicotine Use [ ] Yes [ ] No

Amiodarone Co-Administration [ ] Yes [ ] No

The customized report will not be provided unless all of this information is provided.

For questions, contact an ARUP genetic counselor at (800) 242-2787, ext. 2141

Master Label