



Medical History for Procedure: CT Lung Biopsy

Legend: CT = Computed Tomography

Diagnosis: _____

Allergies: _____

Medications Relevant for the Procedure:

The patient is taking the following medications:

- | | |
|--|---|
| <input type="checkbox"/> Apixaban (<i>Eliquis</i>) | <input type="checkbox"/> ASA (<i>Aspirin</i>) |
| <input type="checkbox"/> Brillinta (<i>Ticagrelor</i>) | <input type="checkbox"/> Coumadin (<i>Warfarin</i>) |
| <input type="checkbox"/> Dabigatran (<i>Pradaxa</i>) | <input type="checkbox"/> Edoxaban (<i>Lixiana</i>) |
| <input type="checkbox"/> LMWH (e.g. <i>Dalteparin, Lovenox</i>) | <input type="checkbox"/> NSAIDs |
| <input type="checkbox"/> Plavix (<i>Clopidogrel</i>) | <input type="checkbox"/> Rivaroxaban (<i>Xarelto</i>) |
- The patient has been advised to **HOLD** the checked medications as per the Procedure Risk Guidelines*
- Patient is NOT taking any anticoagulants**

Laboratory Results:

Hgb _____ Plts _____ INR _____ Pending Date: _____

Relevant Medical History: (Please select/circle all that apply)

- Bleeding Disorders
- Cardiac History (*Coronary stents < 3months, valve replacement, CABG, MI <6 weeks*)
- CVA / TIA
- Diabetes Insulin
- Emphysema / Severe COPD / Home O2 use
- Hypertension
- Renal disease Dialysis
- Sleep Apnea / CPAP use
- None of the above**

MRP _____ (required for inter-hospital transfer patients only)

Referring Physician (Printed Name)

Date (yyyy/mm/dd)