McMaster Platelet Immunology Laboratory
TEL (905) 525-9140 ext. 22414 FAX (905) 529-6359 http://fhs.mcmaster.ca/plateletimmunology/

Mailing Address:
Platelet Immunology Laboratory
McMaster University-Department of Medicine
1280 Main Street W, HSC-3H42
Hamilton, ON L8S 4K1

Shipping Address:
Platelet Immunology Laboratory
McMaster University-Department of Medicine
1200 Main Street W, HSC-3H42
Hamilton, ON L8N 3Z5

Investigation of Vaccine-Induced Thrombotic Thrombocytopenia (VITT)
Blood Test Requisition Form

Patient Name: Last: _____ First:_____
ID Number for Reporting: _____ Sex: ☐ M / ☐ F
Date of Birth (DD-MMM-YYYY): _____
Sample Collection Date (DD-MMM-YYYY): _____
Hospital/Clinic: _____
Ordering Physician Name: _____
Ordering Physician Phone Number: _____
Fax for Report: _____
Billing Address: _____

Sample requirements: 2x red top (serum) whole blood; and
2x blue top (sodium citrate- plasma) whole blood

Instructions: Separate serum and plasma from whole blood samples and ship frozen.
Complete this form, print the form, and include with shipment of specimens.

Ship to: Platelet Immunology Laboratory, McMaster University, HSC 3H42
1200 Main Street West, Hamilton, Ontario L8N 3Z5 (TEL: 905-525-9140 ext. 22414)
All samples will be processed urgently.

The following clinical information is required

1. Type of COVID-19 vaccine received (please mark 1st dose and 2nd dose, if applicable):
☐ AstraZeneca ☐ COVISHIELD ☐ Pfizer-BioNTech ☐ Moderna
☐ Janssen ☐ Other:_____ ☐ None ☐ Unknown

2. Date of most recent vaccination (DD-MMM-YYYY):_____ **or** ☐ Date Unknown
This vaccination was the: ☐ 1st dose ☐ 2nd dose (if 2nd, date of 1st dose: _____) ☐ Unknown

3. Platelet count at the time of sample collection: _____ $x10^9$/L (normal range 150-400 $x10^9$/L)
Date of platelet count (DD-MMM-YYYY):_____

Nadir platelet count: _____ $x10^9$/L (normal range 150-400 $x10^9$/L)
Date of nadir platelet count (DD-MMM-YYYY):_____

4. Thrombosis: ☐ Yes ☐ No Date of Thrombosis (DD-MMM-YYYY):_____
If Yes: anatomical site of thrombosis (check all that apply):
☐ cerebral vein thrombosis ☐ portal vein/splanchnic vein thrombosis
☐ leg deep vein thrombosis (DVT) ☐ arm DVT ☐ pulmonary embolism
☐ acute coronary syndrome ☐ acute arterial clot ☐ stroke
☐ other: _____

5. Was patient receiving heparin before the onset of symptoms? ☐ Yes ☐ No
   If Yes: ☐ unfractionated heparin; or ☐ low molecular weight heparin

   Was patient receiving heparin when the sample was collected? ☐ Yes ☐ No
   If Yes: ☐ unfractionated heparin; or ☐ low molecular weight heparin

6. Date of first symptom onset (DD-MMM-YYYY): _____
Provide a brief description of the clinical presentation:
_____
_____
_____

7. Was patient treated with intravenous immune globulin (IVIG)? ☐ Yes ☐ No
   If Yes: Date of IVIG (DD-MMM-YYYY):_____

8. Was patient treated with plasmapheresis? ☐ Yes ☐ No
   If Yes: Date of plasmapheresis (DD-MMM-YYYY):_____