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GRADUATE SCHOOL OF BIOMEDICAL SCIENCES
UT HEALTH SCIENCE CENTER
DEPARTMENT OF PATHOLOGY

MOLECULAR DIAGNOSTICS LABORATORY
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Pharmacogenetics (PGx) Supplemental Form

Patient name: _____

Birth Date: _____

Sex: _____

Ethnicity: _____

Weight_____ lbs; or _____kgs

Height _____feet and _____ inches; or _____cms

Smokes ○ Yes ○No

Liver disease ○ Yes ○No

Clinical indication for initiation of therapy (please list) _____

Baseline INR _____

Target INR _____

Amiodarone/Cordarone® Dose _____ mg/day

Statin/HMG CoA Reductase Inhibitor ○Yes (please list name) _____ No ○

Any Azole (eg. Fluconazole) ○Yes ○No

Sulfamethoxazole/Septra/Bactrim/Cotrim/Sulfatrim ○Yes ○No

Note: Above questions are adopted from www.warfarindosing.org

Please fill all blanks above to allow estimation of warfarin dose for each patient.