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Patient information	**Submitted by**
Last name First name Date of birth (dd/mm/yyyy) ☐ male ☐ female Address (Street) Zip code city State/country	Name Address: Signature Date:

Billing address
Name and address of institution

☐	**Vaccine-induced immune-thrombocytopenia** - **6 ml native-blood (serum)!!** - **6 ml EDTA-blood** - **6 ml citrate-blood** **We will perform following tests:** Modified HIPA test (PIPA) / HIT Screening test / HIPA test (If an examination is not desired, please specify)

Vaccination	☐ AstraZeneca ☐ BioNTech ☐ Moderna ☐ other: Lot number, if known: Date of vaccination: ☐ first –/ ☐ second vaccination One or several symptoms during first 48 hours after vaccination: ☐ headache ☐ fever ☐ chills ☐ limb pain ☐ flu-like symptoms ☐ discomfort ☐ others:
Onset of symptoms	
Thrombosis	☐ yes ☐ no Where?
Hemorrhage	☐ yes (petechiae/hematomas) ☐ no Where?
Drugs BEFORE thrombosis	☐ estrogen containing drugs (e.g. Birth control pill) ☐ NSAIDs ☐ Heparin (UFH/LWMH)
Anticoagulation	☐ *i.v.* IgG ☐ UFH/LWMH ☐ DOAK, specify: ☐ VKA ☐ others:
Platelets	Platelet count at admission: Gpt/L Lowest platelet count after admission: Gpt/L HIT Screening test, specify: ☐ positive ☐ negative

Place/Date/Seal: Signature: