

Note: It is not required to complete this source worksheet if the information below is clearly documented in other records.

Was the HAS-BLED Score completed? (Select only one)	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If no, complete a protocol deviation</i>
Date completed	____ / ____ / ____ (DD/MMM/YYYY)
HAS-BLED Score (Check all that apply)	<input type="checkbox"/> None of the below <input type="checkbox"/> Hypertension (<i>Uncontrolled, >160 mmHg systolic</i>) <input type="checkbox"/> Renal disease (<i>Dialysis, transplant, CR >2.26 mg/dL or >200 µmol/L</i>) <input type="checkbox"/> Liver disease (<i>Cirrhosis or bilirubin >2x normal with AST/ALT/AP >3x normal</i>) <input type="checkbox"/> Stroke history <input type="checkbox"/> Prior major bleed or predisposition to bleeding <input type="checkbox"/> Labile INR (<i>Unstable/high INRs, time in therapeutic range <60%</i>) <input type="checkbox"/> Age > 65 years <input type="checkbox"/> On medications that predispose to bleeding (<i>aspirin, clopidogrel, NSAIDs</i>) <input type="checkbox"/> Alcohol use (<i>≥8 drinks/week</i>)
Score	<i>Auto-Calculated in EDC</i>

Site Personnel Signature

____ / ____ / ____
Date (DD/MMM/YYYY)