Bleeding Disorder Referral Form

Please complete the following and fax with clinical documentation

Referral Process

1. PATIENT INFORMATION

Name:

Address:

City: State: Zip:

Home Phone: Other Phone:

Email:

DOB: Social Security #:

Gender: ☐ M ☐ F Height: Weight:

2. PHYSICIAN INFORMATION

Physician's name:

License #: NPI #:

DEA #:

Address:

City: State: Zip:

Office Contact:

Phone: Fax:

Allergies:

3. DIAGNOSIS

☐ Hemophilia A (D66)
☐ Hemophilia B (D67)
☐ von Willebrand (D68) Type I, Type II, Type III
☐ Factor X Deficiency
☐ Factor XIII Deficiency
☐ Other _____

Factor severity level: _____% or ☐ Mild ☐ Moderate ☐ Severe
Hx of inhibitor: ☐ No ☐ Yes If yes, _____ BU

4. INSURANCE INFORMATION

Please submit copies of the front and back of primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION

Medication Dose Frequency

PRODUCT NAME: _____

PROPHYLAXIS: Dose: units ±10% (other %) Frequency: _____

PRN TREATMENTS: Dose: units ±10% (other %) Frequency: _____

Stimate _____

Amicar _____

Emla _____

DATE SHIPMENT REQUIRED: _____

ADDITIONAL MEDICATIONS: _____

6. SPECIAL INSTRUCTIONS:

Access: ☐ PIV ☐ Central Line Type: _____ # of Lumens: _____
☐ Flush Orders: _____

Is nursing needed: _____

Other instructions: _____

PHYSICIAN'S SIGNATURE (required): _____ Date: _____

Prescription is valid for one year unless otherwise indicated.
The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.