

Bleeding Disorder Referral Form

Please complete the following and fax with clinical documentation to 844.797.5050 or SoleoFactorReferrals@soleohealth.com

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 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

FACTOR 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: _____