Bleeding Disorder Referral Form

Fax #: 844-635-5250

Patient Information

Patient Name: ____ Date:________________ SS#: ___________________

Address: ____ City: _______________________ State: ______Zip________

Phone(day): _________________________ Phone (night): _______________________ DOB: ____________________________

Sex: Male ____ Female ____ Height _________ Medication Needed By: ______________________________

Rx Insurance: _______________________ ID #: __________________ Group #: _________________ Phone:_______________

Medical Insurance: _______________________ ID #: __________________ Group #: _________________ Phone :_____________

Secondary Insurance: _____________________ ID#: __________________ Group #: _________________ Phone :_____________

Medical Assessment

Bleeding Disorder Type: ___ A ___ B ___ vWD _ __ Other: __________________________________ Height: ______ Weight: ______

Inhibitor: ___ No ___ Yes (______ B.U.) **Allergies:** ____

Vascular Access: ___ Peripheral ___ PICC ___ Port ___ Other: _______________________________

Clotting Factor Orders – *****Complete this form or attach additional prescriptions*****

Brand Name: _______________________ **Dose:** __________ **Quantity:** ________ **Frequency:** _____________
Brand Name: _______________________ **Dose:** __________ **Quantity:** ________ **Frequency:** _____________
Brand Name: _______________________ **Dose:** __________ **Quantity:** ________ **Frequency:** _____________

Dosage: Mild units / kg ______________ Severe Units / kg: _________________
Prophylaxis: Dispense ______________ doses / week for a duration of _____ months
Episodic: Dispense ___________ doses for mild / __________ doses for severe

Ancillary Medications / Supplies / Nursing

__ **Heparin** ___ units / ml ___ ml flush
__ **Saline** ___ ml _____ ml flush
__ **Amicar** ____ mg Directions: __________________________
__ **Stimate** 1.5mg / ml spray in __ each or __both nostrils, as directed
__ **Emla** Apply topically as needed to IV site 30-60 minutes prior to insertion prn. ______
__ **LMX** Apply topically as needed to IV site 30-60 minutes prior to insertion prn. ______

__ **Skilled Nursing** to be provided for ___ teaching or ___ infusion
__ Other: ____

Physician Prescription Orders

Physician Name: ___________________________Date: ______________ Phone: _____________________ Nurse:______________

Clinic: __________________________ Fax: ______________________ License #:__________________ DEA #: _______________

Physician Signature: ____ Date: ___________________________

Substitution permitted

****By signing this form and utilizing our services, you are authorizing Reliant Healthcare and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies. ****