

Bleeding Disorders referral form



Patient info	Patient name		Phone #	
	Address			
	DOB	Sex	Marital status	
	Patient representative			
Medicaid	Complete this section for Medicaid patients ONLY			
	Last 4 digits of SSN _____ OR Medicaid ID # _____			
Primary insurance	Primary insurance		Phone	
	Name of insured		Relationship	
	Last 4 digits of insured SSN	DOB	Employer	
	Group #	Policy #	Member #	
	Prescription/drug card company		Phone	
	Rx BIN #	Group #	Policy ID	
Secondary insurance	Secondary insurance		Phone	
	Name of insured		Relationship	
	Last 4 digits of insured SSN	DOB	Employer	
	Group #	Policy #	Member #	
	Prescription/drug card company		Phone	
	Rx BIN #	Group #	Policy ID	
Clinical	Bleeding disorder type: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> vWD <input type="checkbox"/> Other _____		Height	Weight
	Severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Type vWD _____			
	IV access: <input type="checkbox"/> PIV/butterfly <input type="checkbox"/> PICC <input type="checkbox"/> Implanted port <input type="checkbox"/> Central line		Inhibitor: <input type="checkbox"/> No <input type="checkbox"/> Yes (___ B.U.)	
	Target joint(s): <input type="checkbox"/> No <input type="checkbox"/> Yes Location _____		Allergies	
Additional clinical information				

41 Rachel Drive, Suite 1 | Nashville, TN 37214 | Phone: 866.712.5007 | Fax: 800.330.0756

Please fax your completed form, along with a copy of the front and back of the patient's insurance ID cards, to: 800.330.0756.

Questions? Please call 866.712.5007.

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Clotting factor orders—Complete this form OR attach prescription below.

Brand name	Dose	Qty	Frequency
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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

<input type="checkbox"/> Amicar® _____ mg Directions	<input type="checkbox"/> Heparin _____ units/mL _____ mL flush
<input type="checkbox"/> Stimate® 1.5 mg/mL spray in <input type="checkbox"/> each <input type="checkbox"/> both nostril(s), as directed	<input type="checkbox"/> Saline _____ mL _____ mL flush
<input type="checkbox"/> Emla® Apply topically as needed to IV site 30–60 minutes prior to insertion prn. _____	
<input type="checkbox"/> LMX™ Apply topically as needed to IV site 30–60 minutes prior to insertion prn. _____	
<input type="checkbox"/> Cryo-Cuff® to be applied to affected site/joint prn _____. Site _____	
<input type="checkbox"/> Skilled nursing visits to be provided for infusions <input type="checkbox"/> Skilled nursing visits to be provided for teaching	
<input type="checkbox"/> Other	

Prescriber name and title	Office contact		
Address			
Phone #	Fax #		
License #	UPIN #	NPI #	DEA #

Attach prescription form here.

Refills _____ Refill x _____ year/month

Date _____ Time _____

(Physician attests this is his/her legal signature. NO STAMPS.) By signing, I certify that the above therapy is medically necessary.

Prescriber signature _____ Dispense as written _____ Substitution allowed _____

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

This prescription is valid only if transmitted by means of a facsimile machine.

The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

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