Bleeding Disorders referral form

Please fax completed copies to **1-800-311-0185**
Or call **1-855-855-8754**
Attach insurance card(s)

PATIENT INFORMATION

Patient ○ Adult ○ Pediatric	Gender: ○Male ○ Female		**Physician orders**	
Patient name:			Brand name:	
Parent name:			Prophylactic dose:	(+/-___%)
DOB:	SSN:		Freq:	Qty:___Refills:___
Height:	Weight:		Bleed dose:	(+/- ___%)
Allergies:			Freq:	Qty:___Refills:___
Address:			Bleed dose:	(+/- ___%)
City:	State:	Zip:	Freq:	Qty:___Refills:___
Phone:	Cell:		Bleed dose:	(+/- ___%)
Emergency contact:			Freq:	Qty:___Refills:___
Phone:	Relationship:		IV access: ☐ PIV/Butterfly needle ☐ CVAD ☐ Implantable port	

Insurance	☐ Front and back of insurance card to follow	
	Primary	**Secondary**
Insurance:		
Phone:		
Policy #:		
Group:		

☑ Flush PIV with Sodium Chloride 0.9%: 5mLs pre- and post-infusion. *If Port access: Sodium Chloride 0.9%, 10mls pre- and post-infusion followed by Heparin 100 units/mL, 5mLs as final lock for patency (for other orders, contact physician).*

☑ Nursing to administer and teach prescribed medication and establish and/or maintain IV access device as required.

☑ Pharmacy to dispense needles, syringes, HME/DME in quantity sufficient to complete therapy as prescribed.

Diagnosis (Please select a diagnosis and severity level, if appropriate)

☐ D66: Hereditary factor VIII ○ Mild ○ Moderate ○ Severe	☐ D68.2: Hereditary factor XI deficiency ○ Mild ○ Moderate ○ Severe
☐ D67: Hereditary factor IX ○ Mild ○ Moderate ○ Severe	☐ D68: Hereditary deficiency of other clotting factors
☐ D68.1: Von Willebrand's ○ Mild ○ Moderate ○ Severe	☐ D68.311: Acquired hemophilia

☐ Other:

Patient has inhibitor? ○ Yes ○ No If positive, ○ > 5 BU or ○ ≤ 5 BU or ○ unknown

Target Joints:

☑ **Anaphylaxis kit order**

Infusion reaction management x 1 year

Mild
- Slow infusion rate by 50% until symptoms resolve. Resume at previous rate as tolerated.
  ☑ DiphenhydrAMINE PO ○ 25mg ○ 50mg ○ ___mg Dispense DiphenhydrAMINE 25mg capsules x4

Moderate
- Stop infusion, resume at 50% when symptoms resolve.
  ☑ DiphenhydrAMINE IV ○ 25mg ○ 50mg ○ ___mg Dispense DiphenhydrAMINE 50mg capsules x1

Severe (Anaphylaxis) *Call 911* Notify Prescriber
- Stop infusion and remove tubing from access device to prevent further administration
- Initiate 0.9% NaCl 500mL/hr IV OR ____ mL/hr ☑ Dispense 0.9% NaCl 500mL x 1
- **Administer EPINEPHrine 1 mg/mL by weight (Wt.) as an IM injection into lateral thigh**

Wt > 66 lbs (30 kg) 0.3 mg/.3mL	Wt 33 - 66 lbs (15–30 kg) 0.15 mg/0.15mL	Wt < 33 lbs (15 kg) 0.01 mg/kg

- Repeat EPINEPHrine in 5-15 min if symptoms persist
- Administer CPR if needed until EMS arrives

☐ Dispense EPINEPHrine Pen Junior 0.15mg x2 ☐ Dispense EPINEPHrine Pen 0.3mg x2

PHYSICIAN INFORMATION

Name: _____ Address: _____

Practice: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ NPI: _____ Contact: _____

By signing, I certify/recertify that the above therapy, products and services are medically necessary and that this patient is under my care. I have received authorization to release the above referenced information and medical and/or patient information relating to this therapy. Pharmacy has my permission to contact the insurance company on my behalf to obtain authorization for patient.

Substitution permissible Signature: _____ Date: _____

Dispense as written Signature: _____ Date: _____