

Patient information

Patient name _____

DOB _____

Mobile number _____

Weight _____ kgs lbs

Diagnosis Hemophilia a (congenital factor viii deficiency)
 Other _____

Allergies NKDA _____

Medication instructions

Pre-medications N/A
 Provider prescribed: _____

Medication order Dose Frequency
 For routine prophylaxis 50 iu/kg once weekly N/A
 For on - demand treatment and control of bleeding episodes and preoperative management: 50 iu/kg Other _____
 Other _____

Medication route IV
 Other _____

Lab order (Include frequency) Please list any labs to be drawn by the infusion clinic:
 N/A

Prerequisites Please include the following with your fax submission: Labs and tests supporting diagnosis | Office / progress notes | Demographics | Factor viii inhibitor testing within the past 30 days

Please send to Columbia, MD Silver Spring, MD Bowie, MD Frederick, MD

Referring provider information

Referring provider name _____ NPI _____

Practice name _____

Point of contact Name _____ Email _____ Phone _____

Provider signature _____ Date _____