PRINT

Phone: (855) 379-4250
Fax: (225) 243-7957

HaloCare
Compassionate Care, Divine Service

Hemophilia Referral Form

Last Name _____ First _____ DOB (mm/dd/yyyy) _____

Address _____ City _____ State, ZIP _____

Social Security # _____ Is patient age 18 or older? ☐ Yes ☐ No ☐ M ☐ F

Home Phone: _____ If no, parent/legal guardian name: _____

Cell Phone: _____ Work Phone: _____ Email: _____

Emergency contact name _____ Phone: _____

Primary Insurance Name _____ Policy # _____ Group # _____

Policy Holder Name _____ DOB _____ Insurance Phone # _____

Rx Group Number _____ Bin # _____ PCN # _____

Diagnosis: ☐ Hemophilia A (286.0) ☐ Hemophilia B (286.1) ☐ von Willebrand Dis (286.4)
☐ Other: _____

Severity: ☐ Mild ☐ Moderate ☐ Severe ☐ vWD Type _____ Inhibitor ☐ Yes ☐ No

Allergies: _____ Height: _____

Weight: _____

IV Access: ☐ Medi-Port ☐ PICC ☐ Central Line ☐ Peripheral ☐ Other _____

Prescription: Frequency: ☐ PRN ☐ Prophy _____

☐ Advate	☐ Feiba	☐ Kogenate-FS	☐ Wilate
☐ Alphanate	☐ Helixate	☐ NovoSeven	☐ Xyntha
☐ Alphanine	☐ Hemofil-M	☐ Recombinate	☐ Amicar
☐ Benefix	☐ Humate-P	☐ Rixubis	☐ DDAVP
☐ Corifact	☐ Koate-DVI	☐ Stimate Nasal	

☐ EMLA Cream/ ☐ NaCL flush 10 ml ☐ Heparin 10u/ml 10ml ☐ Heparin 100u/ml 10ml

☐ Other: _____

Directions: _____

Dispense Quantity: _____ ☐ 1 month supply Refills: _____

Physician Name _____ NPI # _____ DEA# _____

Address _____ City/State _____ ZIP _____

Phone ( ) _____ Fax # ( ) _____ Office Contact _____

Date: _____

Physician Signature: _____ No stamps please _____

Dispense as written Substitution Allowed