BLEEDING DISORDERS REFERRAL FORM

210 Rock Road | Glen Rock, NJ 07452
TEL: 201-444-3200 | FAX: 201-444-5792
Toll Free: 866-888-3200

Today's Date

☐ **CURRENT PATIENT**
☐ **NEW PATIENT**

Patient Name ______ SS# ______ DOB ______
Address ______ Apt # ______ ☐ Male ☐ Female
City ______ State ______ Zip ______ Daytime Tel ______ Cell ______
Email ______
Ship to Patient at ☐ Home ☐ Work OR Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed ______

☐ D66 Hereditary Factor VIII Deficiency
☐ D68.1 Hereditary Factor XI Deficiency
☐ D68.0 von Willebrand Disease
☐ D68.9 Coagulation Defect, Unspecified
☐ D67 Hereditary Factor IX Deficiency
☐ D68.2 Hereditary Deficiency of other Clotting Factors
☐ D68.4 Acquired Coagulation Factor Deficiency
☐ Other ICD-10 ______

Description ______
Baseline factor percent ______ Target joint(s) ☐ No ☐ Yes ______ Inhibitor: ☐ No ☐ History ☐ Current ______BU/mL
Inhibitor protocol______
DNR/Advance directive status: ☐ Received ☐ N/A Hep B, Hep C, HIV or TB positive? (circle) Date chest x-ray______
Allergies ______ Comorbidities ______
Current Medications (if necessary, please fax a complete list) ______
Vascular access: ☐ Peripheral ☐ Port ☐ Other Weight ______ ☐ kg ☐ lbs Height ______ ☐ cm ☐ in

Insured's Name ______ Relation to Patient ______
Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# ______ Prescription Card ☐ Yes ☐ No If Yes, Carrier ______
Tel ______ Fax ______ Policy/Group# ______
Bin# ______ Pcn# ______ RXID# ______ RX Group# ______

Prescriber's Name ______ Office Contact ______
Street Address ______ Suite# ______ City ______ State ______ Zip ______
Tel ______ Fax ______ Email ______
License# ______ NPI# ______ UPIN# ______ DEA# ______

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ EpiPen Adult (0.3 mg) as directed for reactions, qty:1 ☐ EpiPen Jr (0.15 mg) as directed for reactions, qty:1

Factor VIII recombinant: ☐ Advate ☐ Helixate FS ☐ Kogenate FS ☐Recombinate ☐ Xyntha ☐ Other: ______
Plasma derived: ☐ Hemofil M ☐ Monoclate-P ☐ Other______
Approximate units and directions:______ Dispense qty: ______ Refills:______

Factor VIII and von Willebrand plasma derived: ☐ Alphanate ☐ Humate-P ☐ Koate-DVI ☐ Wilate ☐ Other:______
Approximate units ☐ VWF ☐ Factor VIII and directions: ______ Dispense qty: ______ Refills:______

Factor IX recombinant: ☐ BeneFix ☐ Alprolix ☐ Rixubis ☐ Other ______
Plasma derived: ☐ AlphaNine SD ☐ Mononine ☐ Other: ______
Approximate units and directions:______ Dispense qty: ______ Refills:______

Factor VII recombinant: ☐ NovoSeven RT ☐ Other______
Dose (mg) and direction: ______ Dispense qty: ______ Refills:______

Activated Prothrombin Complex Concentrates plasma derived: ☐ Feiba VH ☐ Other______
Approximate units and directions:______ Dispense qty: ______ Refills:______

Prothrombin Complex Concentrates plasma derived: ☐ Bebulin VH ☐ Profilnine SD ☐ Other
Approximate units and directions:______ Dispense qty: ______ Refills:______

Stimate 1 spray in ☐ one nostril ☐ each nostril ______ Dispense qty: ______ Refills:______

Amicar ☐ syrup ☐ 500/1000 mg tab Dose and directions: ______ Dispense qty: ______ Refills:______

Other (continuous infusion, Rituxan. vancomycin, etc): ______

Line care: ☐Sodium chloride 0.9% 5-10ml ☐3-5 ml Heparin (☐ 10 units/ml ☐ 100 units/ml) ☐ Other: ______
☐ Apply 30-60 minutes prior to access (☐ Emla 30 gram ☐ LMX 30 gram) ☐ Other: ______
Nursing orders: ☐ Skilled nurse to infuse/teach mixing infusion, self-monitoring, other aspects of care ______
Lab orders: ______
Supplies: ☐ All infusion and prevention supplies as needed and/or: ______

By signing this form and utilizing our services, you are authorizing Glen Rock Medical Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS)______ **Date**______

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Please fax completed referral form to **Glen Rock Medical Pharmacy** at **201-444-5792** Visit **www.GLENROCKMEDICALPHARMACY.com** for online fillable forms.

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