

Physician's Form



TO BE COMPLETED BY HEALTH CARE PROVIDER (PHYSICIAN/NURSE)

Name of patient _____ Date Of Birth ___/___/___

Date of Last Exam _____ Weight _____ Male Female

Affected by bleeding disorder? Yes No (If NO, Please skip to Section 5 below)

1. Diagnosis

Factor VIII deficiency _____ Factor IX deficiency _____ Factor Activity Level ___%

VWD Type I _____ II _____ III _____ Inhibitor? Yes ___ No ___ Inhibitor Titer _____
 IIA _____ IIB _____ IIM _____ IIN _____
 Date of last inhibitor test ___/___/___

Carrier VIII _____ IX _____ Immune Tolerance?
 On it now On it in the past Never on it

Other factor deficiency (type) _____
 Platelet dysfunction (type) _____

2. Treatment

What brand of factor is used? _____

Does this child self-infuse? Yes Yes, with assistance No No, but would like to learn

Target joints _____

3. Factor Therapy	Minor		Major	
	Factor Dose	Frequency	Factor Dose	Frequency
Prophylactic Therapy				
Minor bleeds/soft tissue of muscle				
Joint bleeds				
Major bleeds				
Trauma or Head Injury				

4. Other Meds for Bleeding Episodes	Dose	Frequency

5. Other Medications including over-the-counter

Drug Name and Strength	Dose	Frequency

6. Psychosocial Development

Is the child's development appropriate for his/her age? Yes No

If No, at what approximate age does the child function? _____

Pertinent Psychosocial Information (Any member of medical team may complete) _____

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Patient Information

Patient Name _____ Date of Birth ___/___/___

	Normal	Abnormal	Explain Abnormalities
Head & Neck	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes & Ears	<input type="checkbox"/>	<input type="checkbox"/>	
Nose & Throat	<input type="checkbox"/>	<input type="checkbox"/>	
Dental	<input type="checkbox"/>	<input type="checkbox"/>	
Chest	<input type="checkbox"/>	<input type="checkbox"/>	
Heart	<input type="checkbox"/>	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
Extremities	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	
Psychological	<input type="checkbox"/>	<input type="checkbox"/>	
Height/Weight	<input type="checkbox"/>	<input type="checkbox"/>	

Drug / Clotting Factor / Food Allergies

	Name	Type of reaction	Name	Type of reaction
Drug/Clotting Factor				
Food Allergies				

If the child had any hospitalizations in the past year please give dates and reasons _____

Please list any ongoing other problem(s) / Other Diagnosis

Any General Restrictions?

Signature of Provider
(SIGNATURE IS MANDATORY)

Print Name

Address

Clinic / Day Phone

Emergency / On Call Phone

Date