SOLEO HEALTH®
Innovators in Specialty Infusion

www.soleohealth.com
Phone: 610.200.6052
Toll Free: 844.747.4040

Bleeding Disorder Referral Form

Please complete the following and fax with clinical documentation to 844.969.5050 or BDreferralteam@soleohealth.com

Referral Process

1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Name:	Physician's name:
Address:	License #: NPI #:
City: State: Zip:	DEA #:
Home Phone: Other Phone:	Address:
Email:	City: State: Zip:
DOB: Social Security #:	Office Contact:
Gender: ☐ M ☐ F Height: Weight:	Phone: Fax:
Allergies:	

3. DIAGNOSIS

☐ Hemophilia A (D66)
☐ Hemophilia B (D67)
☐ von Willebrand (D68) Type I, Type II, Type III ☐ Other: _____

Factor severity level: _____% or ☐ Mild ☐ Moderate ☐ Severe
Hx of inhibitor: ☐ No ☐ Yes If yes, _____ BU

4. INSURANCE INFORMATION

Please submit copies of the front and back of primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION

Medication Dose Frequency

FACTOR NAME: _____

PROPHYLAXIS: Dose: units +/- 10% (other %) Frequency: _____

PRN TREATMENTS: Dose: units +/- 10% (other %) Frequency: _____

Stimate _____
Amicar _____
Emla _____

DATE SHIPMENT REQUIRED: _____

ADDITIONAL MEDICATIONS: _____

6. SPECIAL INSTRUCTIONS:

Access: ☐ PIV ☐ Central Line Type: _____ # of Lumens: _____
☐ Flush Orders: _____

Is nursing needed: _____

Other instructions: _____

PHYSICIAN'S SIGNATURE (required): _____ Date: _____

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Not applicable in Arizona, please contact your local Soleo Arizona branch for assistance.