



University Specialty Pharmacy
3328 Garfield Ave.
Commerce, Ca 90040
P: 323.201.4488
F: 866.728.4810

Hemophilia & von Willebrands Referral Form

Patient Name: (First) _____ (Last) _____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph: _____ Cell Ph: _____ Work Ph: _____ SS#: _____

Date of Birth: _____ Patient's Height: _____ Patient's Weight: _____ Male Female

Parent/Guardian if child: _____ Address: _____

Primary Insurance: _____ Phone: () _____ **PLEASE ATTACH COPY OF CARD!**

Cardholder Name: _____ ID# _____ Group# _____ Employer: _____

Patient Drug Allergies: _____

CLINICAL INFORMATION Bleeding Disorder Diagnosis: A B vWD Other _____

Severity: Severe Moderate Mild Type vWD _____ Inhibitor: NO YES ___ B.U.

IV Access: _____ Additional Clinical Data: _____

_____ Nursing: NO YES

PRESCRIPTION

Amicar®
 Stimate®
 Clotting Factor Name: _____ Target Dose: _____ units
 Clotting Factor Name: _____ Target Dose: _____ units
 Other _____

SIG: _____ IV Frequency: _____

Dispense Quantity: _____ Refills: _____

Other Instructions: _____

Deliver Product to: Office Patient's Home Other: _____

Physician's Signature _____ **Date**

Physician Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

DEA #: _____ License #: _____ NPI#: _____ State: _____

Office Contact: _____ Email: _____

IMPORTANT NOTE: This fax transmission contains private and confidential information and is intended only for the named addressee. If you are not the named addressee; please immediately notify the sender to obtain instructions as to the disposal of this document. In no event should this material be read or retained by anyone except the named addressee.