Bleeding Disorders Association of South Carolina
formerly, Hemophilia of South Carolina

New Patient Referral Form

Date: _____Referred By/Facility: _____

Referral contact name and number: _____

Special comments or needs: _____

_____

Patient Name: _____

Age: _____ Month of Birth: _____ Gender: _____

Parents Names: (If patient is a minor child_____

Address: _____City/State: _____Zip: _____

County: _____

Phone: _____Cell: _____

E-Mail: _____

Diagnosis: Hemophilia A: _____Hemophilia B: _____ von Willebrand's Disease: _____

Mild: _____ Moderate: _____ Severe: _____ Vwd: Type 1____ Type 2 ____ Type 3 ____ other_____

Do they have an inhibitor: Yes: _____No: _____

Other Bleeding Disorder_____

What programs and/or services do you feel would best serve your patient that we can provide?

_____

Emergency Financial Assistance needed: _____Amount: $_____

Parent Signature (minor): _____

Patient Signature if adult: _____

Send Request to: Bleeding Disorders Association of South Carolina by Fax: 864-244-8287 or E-mail. E-mail to Sue Martin, Executive Director @ sue.martin@hemophiliasc.org.

This consent grants permission to Bleeding Disorder Association of South Carolina to contact the family or individual in order for BDASC to communicate with the referred patient or family about the programs and services we can provide. This consent does not guarantee any services or assistance by BDASC, which is governed by the organizations policies and procedures. All personal information provided in this consent will remain strictly confidential, only to be used for the purpose described and will never be shared with any others.