Oso Home Care, Inc.
Specialty Infusion Services

FACTOR THERAPY REFERRAL FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

INSURANCE INFORMATION

Please provide the following infomration, or attach a photocopy of insurance card, if available.

Insurance Company: _____ Phone: _____

Employee Group Name: _____ Group #: _____

ID #: _____ Subscriber's Name: _____

MEDICAL HISTORY & THERAPY INFORMATION

Diagnosis:

☐ Factor VIII Deficiency (D66) ☐ Factor IX Deficiency (D67) ☐ von Willebrand (D68.0)

☐ Other: _____

Severity:

☐ Mild ☐ Moderate ☐ Severe ☐ Type vWD: _____

Therapy: _____

Frequency:

☐ PRN ☐ Prophylaxis

IVAccess:

☐ PIV ☐ Port ☐ Other: _____

Allergies: _____

Target Joint(s):

☐ Yes, location: _____ ☐ No

Inhibitor:

☐ Yes (_____ B.U.) ☐ No

Oso to provide nursing care? ☐ Yes ☐ No

Is there a nursing agency already assigned to this patient? ☐ Yes ☐ No

PHYSICIAN INFORMATION

Prescriber's Name: _____ Contact's Name: _____

Address: _____

Phone: _____ Fax: _____

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