Telemedicine Hematology Referral Form for Hemophilia/Bleeding Disorders

Phone: 786-567-8310. Fax: 877-370-4375

Email: ariana@hemeoncall.com

Patient Information

Name: _____

DOB: _____ Phone: _____

Address: _____

_____

Email: _____

Name of current hematologist/HTC: _____

Phone: _____

Referring Party/Provider information

Practice/Pharmacy: _____

Contact Person: _____ (person sending this referral form)

Phone: _____

Fax: _____ (number where hematology notes should be faxed)

Email: _____

Patient's Pharmacy/Specialty Pharmacy

- Name of pharmacy: _____
- Phone: _____
- Fax: _____
- Email: _____

Health insurance Information

Health Plan Name: _____

Member ID: _____

If the patient is outside of the State of Florida, please check **YES** below.
Application to Fem Foundation needed, patient will receive Foundation funds for clinical visit: Yes☐ No☐

Include the following documents along with this referral form:
(patients without this information will not be scheduled)

- Clinical Notes
- Lab and Testing results specifically factor levels.
- Insurance information (if applicable)