PATIENT REFERRAL

Please email completed form and prescriptions to hemo-intake@biomatrixsprx.com or fax to Hemophilia Center of Excellence at 1-888-385-2805

Referral taken by _____ Today's Date _____

Patient Information:

Patient Name _____ Patient DOB _____ ☐ Male ☐ Female

Social Security_____ Current Age_____ Height _____ Weight _____

Address _____ Home Phone _____

_____ Cell Phone _____

Delivery Address and Special Instructions _____

_____

_____

Email Address_____ Work Phone _____

Marital Status/Minor? _____ *If Patient is a Minor, provide Parent (Guardian) information:*

Mother's Name_____ Work Phone _____ Cell Phone_____

Father's Name _____ Work Phone _____ Cell Phone _____

Patient Diagnosis:

Diagnosis _____ Severity _____ Port/Access Device _____

Product_____ Dose_____ Quantity on Hand _____

On Prophy? _____ Prophy Schedule _____ Needs Delivery By _____

Self-Infusing? _____ Nursing Needs _____

Ancillaries _____

Allergies/Other Significant Diagnosis_____

Other Medications Taken _____

_____

Treating Center:

Hospital/HTC _____ Okay to call for script? ☐ Yes ☐ No

Physician _____ Phone _____ Fax _____

Nurse _____ Phone _____ Fax _____

Insurance:

Primary Insurance _____ Phone _____

Name of Insured _____ Insured's DOB_____ Relationship to Patient_____

Insured's Employer _____ Subscriber ID _____

Employer Group # _____ Insured's Social Security #_____

Please obtain copies of insurance and pharmacy cards (front and back)

Secondary Insurance_____ Phone _____

Name of Insured _____ Insured's DOB _____ Relationship to Patient _____

Insured's Employer _____ Subscriber ID _____

Employer Group # _____ Insured's Social Security #_____

BioMatrix understands your health information is personal. Protecting your information is important to us. We follow strict Federal and State laws that require us to maintain the confidentiality of your health information.

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