



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: _____ Year 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: 864-236-8663 or E-mail.

E-mail to Sue Martin, Executive Director @ sue.martin@bda-sc.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.