Hemophilia Therapy Referral Form

Patient: _____ **Date**: _____ DOB**:** _____

Order: ☐ PT: evaluate and treat ☐ PT: _____

Diagnosis: Hemophilia A/B VonWillebrand's Disease Other Factor Deficiency

Severity: Mild Moderate Severe

Prophylaxis: Yes No
Schedule: Mon Tues Wed Thurs Fri Sat Sun
Current Treatment: _____

Current Joint Problem(s):
Shoulder R/L Elbow R/L Wrist R/L
Hip R/L Knee R/L Ankle R/L

Status of joint bleed: acute sub acute chronic target joint recurrent pattern
Date of last bleed: _____ Location: _____
Muscle Problem or Bleed _____

Surgical History: _____

Treatment Parameters:

☐ Factor not indicated prior to PT.

☐ Patient to receive factor at least 1 hour prior to PT.

☐ Patient to receive PT within _____ hours after factor infusion.

☐ Home exercises which put stress on joint beyond normal activities of daily life should be done on days patient receives prophylaxis.

****Please observe all precautions/contraindications related to Hemophilia**

Reports: Please send a report back to _____ every _____ weeks and at discharge.

Hemophilia Treatment Center Contact Information:

Hemophilia Treatment Center PT Contact Information:

_____ _____
Physician Signature/Date Physical Therapist Signature/Date