

Referring Provider: _____ Office Phone: _____

Practice Name: _____ Fax: _____

Practice Address _____ PCP Name: _____

Patient Name: _____ MRN# _____

DOB: _____ Cell Phone _____ Home Phone _____ Work Phone _____

Mailing Address: _____

Will a supplied interpreter be needed for this appointment? No Yes Language: _____

Health Insurance: _____ Subscribers Name: _____

Policy #: _____ Group# _____ Subscribers DOB _____

Referral for Diagnostic Coagulation Center

Please select the service requested: Hemophilia Bleeding Thrombosis Other _____**Urgency of Appointment:** Routine - next available Urgent - within 10 days please call (603) 650-6763. Ask to speak with the Clinical Nurse Specialist.**Are records available in eDH.** Yes NoPlease fax copies of the following reports (if available) with this form to (603) 650-6786
or for urgent appointment request please call (603) 650-6763:

- Patient demographics (required)
- Discharge summaries within 5 years
- Medication list (required)
- Surgical/Trauma Notes
- Coagulation office notes (required)
- MRI / CT Scan Reports
- Coagulation blood work (if done)*
- Other pertinent studies related to bleeding or thrombosis

*We do not recommend performing specialized coagulation blood testing prior to the appointment. However, if tests have been done previously, e.g., factor 8, vWF, protein C & S, factor V Leiden etc., please send us the results. Only recent INR values are necessary.

Please note: Incomplete or illegible information on this form may delay scheduling your patient for a coagulation consultation. Please let your patient know that if he/she does not hear from us within 5 days to call (603) 650-6763 for immediate assistance.