American Society of Hematology

Hemophilia Clinical Summary

This document should be shared with and carried by the young adult.	
Administrative	
Date Completed:	Date Revised:
Form completed by:	
Name and number of Medical Records Department:	
Notes:	

Contact Information and Demographics		
Name:		**Nickname:**
Date of Birth:		Preferred Language:
Address:		
Cell #:	Home #:	Best Time to Reach:
E-Mail:		Best Way to Reach: (*Check*) Text Phone Email
Health Insurance/Plan:		Group and ID #:

Emergency Care Plan		
Emergency Contact:	Relationship:	Phone:
Preferred Emergency Care Location:		

Health Care Providers (clinical and emergency information)		
Provider:		
Primary and Specialty		
Clinic or Hospital:		
Daytime Phone:		
Emergency Phone:		
Email:		
Fax:		

School, Work and Home Care Agency Information		
Agency/School	Contact Information	
	Contact Person:	Phone:
	Contact Person:	Phone:
	Contact Person:	Phone:

Common Emergent Plans	Treatment (ie factor plan)
Severe bleed	
Moderate bleed	
Allergies and Procedures to be Avoided	
Allergies	Reactions
To be avoided	Why?
Medical Procedures:	
Medications:	
Diagnoses and Current Problems	
Problem	Details and Recommendations
Primary Diagnosis	Severity (mild, moderate, severe) Preferred replacement product
Secondary Diagnosis	

Medications					
Medications	Dose	Frequency	Medications	Dose	Frequency

Prior Surgeries, Procedures, Specialty Treatment and Recent Hospitalizations

- *Please include blood counts and historical trends.*
- *If patient has chronic abnormalities, please include range.*
- *If hospitalization, please include reason.*

Date	Details
Date	Details
Date	Details
Date	Details
Date	Details

Baseline

Hemophilia Related Care		
Most recent pharmacokinetic data (recovery and half-life)	Date	Results
Prophylaxis	yes/no	If yes, frequency
History of HIV or Hepatitis C testing	yes/no	If yes, test, date and result
Presence of arthropathy	yes/no	Target Joints:
Presence of or history of an inhibitor	yes/no	If Yes
		Date of Acquisition
		Recent Titer/Date:
		IT therapy regimens/dates

		Current bypass agent (s): drug/dose
Genetic Testing (*Please include family testing*)		

Equipment, Appliances, and Assistive Technology

External venous access device	Implanted Venous Access Device	Peripherally inserted central catheter (PICC line)
Other		

Long-term recommendations (i.e. bone density assessments, repeat labs or imaging, and other disease specific recommendations)

Additional information (i.e. psychosocial issues, family, social background, etc.)

Special information that the patient wants health care professionals to know

See attached list for links to disease specific guidelines and resources.

_ Patient/Guardian Signature Print Name Phone Number Date

_ Primary Care Provider Signature Print Name Phone Number Date

_ Care Coordinator Signature Print Name Phone Number Date

Please attach the immunization record to this form.