Bleeding Disorder Supplemental From

Must Be Completed by a Hematologist

Campers Name: ☐ DOB: ☐ Weight (kg): ☐

Please return this completed form to:
Email: admissions@thepaintedturtle.org or **Fax**: 661-724-1566

If there are any questions about this form or camper, please feel free to contact our Medical Director, Kathy Reynolds at (661) 724-1768.

Central Venous Device: ☐ Yes ☐ No Type: ☐

Hemophilia: ☐ A ☐ B or ☐ ☐ Severe ☐ Mod ☐ Mild % Factor level: ☐

History of Inhibitors: ☐ Yes ☐ No Active Inhibitor: ☐ Yes ☐ No

Last Inhibitor Test: ☐ BU Date: ☐

Von Willebrand Disease: ☐ I ☐ II ☐ III ☐ Unknown Levels: VIIIC ☐ % Rcoff: ☐

Other Coag Dx: ☐

TREATMENT:

1) **Immune Tolerance:** ☐ Yes ☐ No

Product (Brand): ☐ Dose: ☐ Frequency: ☐ Days: ☐

2) **Prophylaxis:** ☐ Yes ☐ No

Product (Brand): ☐ Dose: ☐ Frequency: ☐ ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun

3) **Acute Bleeds:**

Product (Brand): ☐

Dose major bleeds (trauma, head injury): ☐ Units or ☐ U/kg Frequency: ☐

Routine bleed dose: ☐ Units or ☐ U/kg Frequency: ☐

Amicar used: ☐ Yes ☐ No Dose: ☐ Frequency: ☐

DDAVP/Stimate: ☐ IV ☐ SQ ☐ Intranasal Approx. Response: ☐ unknown or ☐ VII

General Questions:

Does the child self-infuse? ☐ Yes ☐ No ☐ with assistance ☐ would like to learn

Does the child reliably report bleeding episodes? ☐ Yes ☐ No Details: ☐

Problem Joints: ☐

Does the child have any mobility issues that would require assistive equipment?

☐

Other instructions: ☐

Physicians Signature: ☐ Print: ☐ Date: ☐