



Factor Donation REQUEST FORM

Date: _____ / _____ / _____
Month Day Year

This is a request made by:

- An individual patient A national/local hemophilia society A physician/treatment center

Patient Information

Name of patient:		Birthdate (M/D/Y):
Address:		
		Country:
Telephone:	Fax:	E-mail:
Gender: male or female		
Factor deficiency:	VWD:	Severity:
Patient's weight: _____ Kg or lbs? (circle one)		Does patient have an inhibitor?
Is the patient able to store, mix and infuse factor at home? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Person Making Request

Name of person requesting factor for patient:		
Relationship with patient:		
Address:		
		Country:
Telephone:	Fax:	E-mail:
Have you requested factor from any other organizations for this bleed? Please list:		

Attending Physician Information

Physician name:	Is this physician a hematologist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hospital name:		
Hospital address:		
		Country:
Physician telephone:	Physician fax:	Physician e-mail:

Shipping Instructions

Ship factor to: <input type="checkbox"/> Patient <input type="checkbox"/> Physician <input type="checkbox"/> Hemophilia society	Ship via: <input type="checkbox"/> Fed Ex <input type="checkbox"/> DHL <input type="checkbox"/> Other _____
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Medical Information

Is the patient currently receiving any treatment for this request?

FFP
 Cryo
 Factor concentrate
 Other _____

Please rate this request. Check **one** box below:

Emergency:
 Life threatening
 Limb threatening
 Surgery

Nature of the emergency

Check body part, and circle location of bleed →

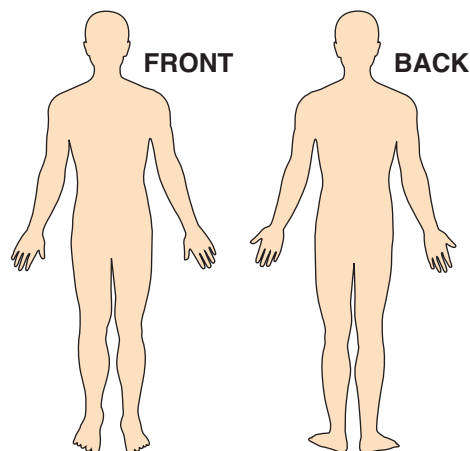
- Head bleed
 GI bleed
 Abdominal bleed
 CNS bleed
 Other _____

Non-emergency:
 Surgery
 Particular bleed

a. List body part: _____
 b. Circle location of bleed →

- Prevention/on-demand
 Bulk shipment for camp (request at least 3 months in advance)
 Emergency reserves (societies and HTC's only)
 Other: _____

Circle location of bleed



Type of factor concentrate requested:
 VIII
 IX
 Other _____

Assay size needed:
 250 IUs _____
 500 IUs _____
 1000 IUs _____

Total IUs needed: _____

Is your hemophilia society registered with the World Federation of Hemophilia?
 Yes
 No

I declare that the above information is true to the best of my knowledge. I will take full responsibility to ensure that this medicine is used only for the patient and medical situation listed above. I will complete and return LA Kelley Communications' documentation as stated in its Factor Donation Policy.

X	
Signature of patient/family member (REQUIRED)	Printed name (please print CLEARLY)
X	
Signature of General Secretary or President, national hemophilia society (REQUIRED)	Printed name (please print CLEARLY)
X	
Signature of attending physician from page one (REQUIRED)	Printed name (please print CLEARLY)

DISCLAIMER: LA Kelley Communications, Inc. is providing donated factor for the above patient only and in response to said patient's request. LA Kelley Communications' sole role in this process is to assist with the delivery of the donated factor to the named patient requesting said factor. The donated factor concentrate is to be used only as provided for by the manufacturer and only to treat extended bleeding due to the medical condition of hemophilia or von Willebrand Disease. The factor is not intended for resale or for uses not intended by the manufacturer and is made available to assist with controlling bleeding in the above identified patient. LA Kelley Communications is not responsible for lost, stolen or misplaced product or the manufacture of the product. LA Kelley Communications is not responsible for the condition of the product nor the suitability of the product. LA Kelley Communications does not guarantee that more product will be donated after the above donation is shipped. The manufacturer of the product may not be aware of this shipment.

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