Sugar House Health Center
1280 E. Stringham Ave.
Salt Lake City, UT 84106
801-213-8371

Utah Center for Bleeding and Clotting Disorders

Dear Doctor,

Please find attached a checklist designed to make surgery safer for our patients with bleeding disorders. Please kindly help your patient fill this out and return the completed form to our clinic. After printing, the form may be returned in person, via fax, or scanned via email. We require receipt of the completed checklist at least 14 days prior to the planned procedure or surgery date in order to allow necessary time for peri-operative factor procurement, which includes obtaining insurance approval, as well as ordering, and dispensing medication to the patient's home.

If you have any questions, please call our hematology clinic. We are open Mon-Fri 8am-5pm.

Sincerely,

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PATIENT NAME:

Hemophilia & Von Willebrand Disease: Surgery & Procedures checklist

Questions for Doctor's office: -

1) 1) What is the name and address of the facility performing the surgery or procedure:

a. Name of doctor:

____

b. Doctor's phone number: (______) ______ - __________

c. Name & facility type (hospital, ambulatory clinic, or ambulatory surgical center):

____

d. If inpatient hospital, please provide the phone number to the inpatient pharmacy:

Inpatient pharmacy phone: (______) ______ - __________

e. Address of facility:

_________________________________City: __________________________Zip:_________

2) What is the exact name of the procedure: ____

3) What is the scheduled date of the procedure? Day:_______, Month:______, Year: 20_____

4) Will the patient spend one or more nights in the hospital? Yes ☐ No ☐
   a. If yes, what is the expected *minimum* # of nights and expected *maximum* # of nights:

   Minimum: _____________, Maximum: _____________

5) If spending one or more nights in the hospital, can the surgery be scheduled on a Monday or Tuesday so that the patient is less likely to be discharged home over the weekend?
   Yes ☐ No ☐

6) Can the surgery be scheduled early in the day in case in case one of our benign hematology doctors needs to be reached for advice? Yes ☐ No ☐

7) Is your facility able to order and administer the pre-procedure factor dose? Yes ☐ No ☐

   a) If you cannot order factor, will you allow the patient to bring in their own supply (brown-bag the medication)? Yes ☐ No ☐

      a) If you will allow the patient to bring in their own factor, will your surgery center or clinic help the patient infuse this medication (eg place an IV line, help reconstitute drug and infuse)? Yes ☐ No ☐

PATIENT NAME: ____________________

8) Is anticoagulation (Blood thinners) or anti-platelet therapy typically offered post-procedure? Yes ☐ No ☐
   a. If, yes, write the name of the medications, dose, and duration of treatment:

      Name: ________________, dose: _________________, duration (days):________

      Name: ________________, dose: _________________, duration (days):________

9) Will the patient need physical therapy following surgery? Yes ☐ No ☐
   a. If yes, where? (eg. nursing home, rehab center, outpatient clinic): ______________
   b. How many sessions: _________________________
   c. Length of each session: ______________________
   d. Days of week for each session: ________________

Questions for the patient: -

1) Do you have a preferred factor product that you use to prevent bleeding? Yes ☐ No ☐
   a) If yes, what is the name of the product: _____________________________________

2) Do you have extra factor, some of which could be used for this procedure? Yes ☐ No ☐
   a. If yes, please list the:

      - name of product: ____

      - # of units on each vial: ____

      - # of vials: ____

   b. Is this product expired? Yes ☐ No ☐

3) Do you know how to self-infuse factor? Yes ☐ No ☐
   a. If not, do you have a family member who can help? Yes ☐ No ☐

4) Will you need us to see if home health nursing services can be arranged to help you infuse factor in your home? Yes ☐ ☐

5) If you are able to self-infuse, will you be able to do this after surgery? Yes ☐ No ☐
   a. If you are having arm or shoulder surgery, will this limit your ability to self-infuse, and if so, can a family member help? Yes ☐ No ☐

6) Please list your preferred home care pharmacy that you would like to use? Note: If you do not have a preferred pharmacy, we would be happy to find a pharmacy for you:

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