GENETICALLY HANDICAPPED PERSONS PROGRAM/ CALIFORNIA CHILDREN'S SERVICES ANNUAL HEMOPHILIA COMPREHENSIVE CENTER EVALUATION

SPECIAL CARE CENTER (SCC)

Name:	Date of Annual:
Address:	Phone #:
City/State/Zip:	SCC Coordinator:

PERSONAL DATA

Client name:	Date of Birth:
Address:	Phone #:
City/State/Zip:	

HEMOPHILIA PROFILE

Home Infusion Program? Yes_____ No_____	If yes: Dosage:
Prophylactic Replacement Therapy? Yes _____ No _____	If yes: factor name, if specified by prescribing MD:
Demand Replacement Therapy? Yes _____ No _____	If yes: factor name, if specified by prescribing MD:
Target Bleeding Sites:	Frequency of Bleeds:

MEDICAL HISTORY

Diagnoses:	Allergies:	Height:	Weight(kg):
Hospitalizations/Surgeries:			
Dental:			
Other Medical Problems:			
Current Medications:			
Pertinent Labs:			
Durable Medical Equipment(DME)/Home Health Agency (HHA):			
Primary Care Physician (if known):			
Other Health Care Providers:			

TEAM MEMBER ASSESSMENTS (If appropriate, attach reports)

Physician	Signature: _____ Date: _____
Nurse Specialist	Signature: _____ Date: _____
Social Worker	Signature: _____ Date: _____
Nutritionist	Signature: _____ Date: _____
Physical Therapist	Signature: _____ Date: _____
Other Team members	Signature: _____ Date: _____

TREATMENT PLAN (NOTE: Please complete Service Authorization Request (SAR) for actual request)

1. 2. 3. 4.
Follow Up:

SCC Physician Name or Physician Designee Name | Title

SCC Physician or Physician Designee Signature | Date