

Infusion Log

Office Use Only
Reviewed by: _____
Date: ____/____/____

Patient name: _____ Treatment Center: _____

DOB: _____ Weight: _____ (lbs.) Diagnosis: Hemophilia A Hemophilia B von Willebrand Other: _____

Comments:

Infusion	Bleed (<input type="checkbox"/> N/A)	Product/Vial Information (or use peel-off labels from vial)				Reason for Infusion	Site of Bleed (<input type="checkbox"/> N/A)		
Date	Start Date	Brand	Brand	Brand	Brand	<input type="checkbox"/> Spontaneous bleed <input type="checkbox"/> Preventive (e.g., sports) <input type="checkbox"/> Prophylaxis (scheduled) <input type="checkbox"/> Surgery-related <input type="checkbox"/> Injury-related <input type="checkbox"/> Follow-up infusion <input type="checkbox"/> Immune tolerance <input type="checkbox"/> Dental procedure <input type="checkbox"/>	<input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Head <input type="checkbox"/> Mouth <input type="checkbox"/> Ribs <input type="checkbox"/> Groin <input type="checkbox"/> Stomach <input type="checkbox"/> Buttocks <input type="checkbox"/> Thigh <input type="checkbox"/> Calf	
Time	Time Elapsed Before First Treatment	Exp. Date	Exp. Date	Exp. Date	Exp. Date				
<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> < 1 hr. <input type="checkbox"/> 1-3 hrs. <input type="checkbox"/> > 3 hrs.	Lot Number	Lot Number	Lot Number	Lot Number				
Total Units		Units	Units	Units	Units				
Date	Start Date	Brand	Brand	Brand	Brand	<input type="checkbox"/> Spontaneous bleed <input type="checkbox"/> Preventive (e.g., sports) <input type="checkbox"/> Prophylaxis (scheduled) <input type="checkbox"/> Surgery-related <input type="checkbox"/> Injury-related <input type="checkbox"/> Follow-up infusion <input type="checkbox"/> Immune tolerance <input type="checkbox"/> Dental procedure <input type="checkbox"/>	<input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Head <input type="checkbox"/> Mouth <input type="checkbox"/> Ribs <input type="checkbox"/> Groin <input type="checkbox"/> Stomach <input type="checkbox"/> Buttocks <input type="checkbox"/> Thigh <input type="checkbox"/> Calf	
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