Bleeding disorders treatment log

Patient name: ____ Date of birth: ___________ Weight: _______ State: _____

Dosage information	Comments	Bleed locations			Reason for treatment (select one)	Did you miss any school or work as a result of this bleed? If yes, how many days?
		Key locations (select one)		Other locations (select one or specify in writing)		
		❑ Head	❑ Stomach			
Date: ____________ Time: __________ Name of factor: ____________________ ________________________________ Lot#: ____________________________ Dose (total number of units infused): __________________		❑ LEFT ❑ Hand ❑ Elbow ❑ Shoulder ❑ Hip ❑ Knee ❑ Ankle ❑ Foot	❑ RIGHT ❑ Hand ❑ Elbow ❑ Shoulder ❑ Hip ❑ Knee ❑ Ankle ❑ Foot	❑ Mouth ❑ Thigh ❑ GI ❑ Upper arm ❑ Lower arm ❑ Other: ____________ ___________________	❑ Prophylaxis ❑ Surgery ❑ Physical therapy ❑ Injury ❑ Preventative infusion (infused before playing sports, etc.) ❑ Spontaneous	❑ Yes ❑ No How many days of school? _______ How many days of work? ________

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