

Infusion log



**Intermountain
Primary Children's Hospital**

The Child First and Always®

Name: _____ Dates: _____ to _____

Contact information

Hemophilia Treatment Center.....801.662.4700
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Heidi Lane, DPT, Physical Therapist.....801.662.4700
Susan Earl, LCSW, Social Worker801.662.4700
Pediatric On-call Hematologist801.662.1000
Utah Hemophilia Foundation801.484.0325
Homecare _____
Phone number _____

Log infusion codes

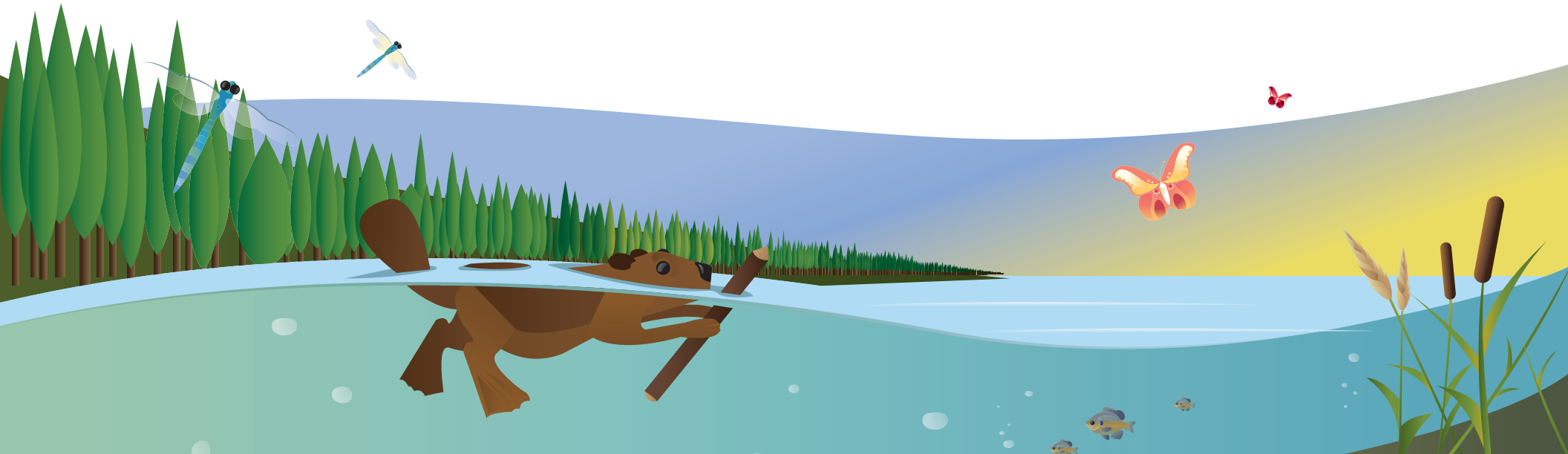
Please write these codes in the log pages to document the reason for treatment and bleed sites.

Reason for treatments

- P** Prophylaxis treatment
- S** Spontaneous bleed
- I** Injury treatment

Location of bleed sites

- | | | |
|----------------------|-----------------------|-----------------------|
| H Head | M Mouth | N Nose |
| LH Left hand | LW Left wrist | LE Left elbow |
| LK Left knee | LA Left ankle | LF Left foot |
| RH Right hand | RW Right wrist | RE Right elbow |
| RK Right knee | RA Right ankle | RF Right foot |



Utah Center for Bleeding and Clotting Disorders at Primary Children's Hospital

Division of Pediatric Hematology and Oncology

Ph: 801.662.4700 Fax: 801.662.4815

Date: _____

Regarding: _____

DOB: _____

_____ is under the care of the
Utah Center for Bleeding and Clotting Disorders (UCBCD) at PCH. They
have a chronic lifetime diagnosis of _____.

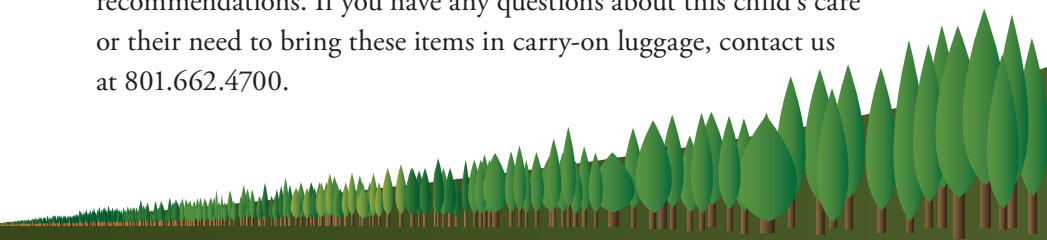
This condition is treated with intravenous infusions of factor concentrate to stop or control bleeding episodes. Patients with this condition who travel must keep treatment products with them at all times to infuse immediately if they begin bleeding. In addition, these factor products are expensive and temperature sensitive. They can break and should not be packed in checked luggage.

To keep this child safe, they must be allowed to carry intravenous medicines and all necessary medical supplies to infuse the medicine on the airplane. These include needles, syringes, and alcohol wipes.

This child is to be treated for minor bleeds with _____
_____ medicine, and for severe bleeding
they are to use _____ medicine.

The vials of factor will vary slightly in dose. The dose may be greater than the recommended units. However, in this case, this child should take the entire dose rather than waste the extra amount.

If this child has a life-threatening bleed, factor should be infused immediately. Do not wait until after tests like an MRI or x-ray. For a joint or life-threatening bleed, call our treatment center for further recommendations. If you have any questions about this child's care or their need to bring these items in carry-on luggage, contact us at 801.662.4700.



Comprehensive clinic summary sheet

Patient: _____

DOB: _____ Date of visit: _____

Diagnosis: HEM A / B: <1% severe, 2%–5% moderate, >5% mild
von Willebrands Disease type _____

Inhibitor status

Negative _____ Positive _____ Not done _____

General care recommendations

INFUSION LOGS: Include date, reason for infusion, factor lot number, and units of factor infused.

**The UCBCD will need this information to update your records, determine target joints, and guide your treatment plan.*

**Some insurance providers require accurate logs to reimburse the factor.*

MEDICAL ALERT: Wear a medical alert identification bracelet or necklace at all times.

AVOID NSAIDS: Avoid medicines containing aspirin or ibuprofen; you may take Tylenol™ (acetaminophen).

SEAT BELT: Your child should wear a seatbelt/child restraint at all times when riding in a car.

HELMET: Your child should wear a helmet for sports that pose risk of head injuries or when riding your bike or skateboarding.

DENTAL CARE: Take your child to the dentist every 6–12 months, make sure they brush daily, and contact the UCBCD at least 2 weeks in advance for any extensive procedures. We can provide you and the dentist a plan to manage bleeding.

PORTS and FEVERS: For temperatures of 101° F or greater OR 100.4° F more than once, call the UCBCD or hematologist on call.

TARGET JOINT: Defined as recurrent bleeding into the same joint 4 or more times in a 6-month period of time.

Your infusion information

Home care pharmacy: _____

Factor brand: _____

Weight: _____ lbs _____ kg

Height: _____ inches _____ cm

Your prophylaxis or episodic dose: _____ unit/kg

Dose: _____

History and physical exam concerns and care instructions

Prescriptions cannot be filled without at least a yearly visit

Date of next visit: _____

Parent/Patient signature: _____

Date: _____

Nurse/Doctor signature: _____

Date: _____





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我們將根據您的需求提供免費的口譯服務。請找尋工作人員協助

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