PROJECT SHARE
It's time to give back

Factor Donation
REQUEST FORM

Date:_____/_____/_____
Month Day Year

This is a request made by:

☐ An individual patient ☐ A national/local hemophilia society ☐ A physician/treatment center

Patient Information

Name of patient:		Birthdate (M/D/Y):
Address:		
		Country:
Telephone:	Fax:	E-mail:
Factor deficiency:	VWD:	Severity:
Patient's weight:_____Kg or lbs? (circle one)		Does patient have an inhibitor?
Is the patient able to store, mix and infuse factor at home? ☐ Yes ☐ No		☐ Yes ☐ No ☐ Unknown

Person Making Request

Name of person requesting factor for patient:		
Relationship with patient:		
Address:		
		Country:
Telephone:	Fax:	E-mail:
Have you requested factor from any other organizations for this bleed? Please list:		

Attending Physician Information

Physician name:		Is this physician a hematologist? ☐ Yes ☐ No
Hospital name:		
Hospital address:		
		Country:
Physician telephone:	Physician fax:	Physician e-mail:

Shipping Instructions

Ship factor to: ☐ Patient ☐ Physician ☐ Hemophilia society	**Ship via:** ☐ Fed Ex ☐ DHL ☐ Other _____

Project SHARE | A Program of Save One Life, Inc. | 441 Main Street, Suite F • Groveland, MA 01834 USA 01.978.352.7652 • Fax: 01.978.225.3492 | share@saveonelife.net • saveonelife.net

Medical Information

Is the patient currently receiving any treatment for this request?

☐ FFP ☐ Cryo ☐ Factor concentrate ☐ Other _____

Please rate this request. Check **one** box below:

Emergency: ☐ Life threatening ☐ Limb threatening ☐ Surgery

Nature of the emergency _____

Check body part, and circle location of bleed ➤

☐ Head bleed ☐ GI bleed ☐ Abdominal bleed

☐ CNS bleed ☐ Other _____

Non-emergency: ☐Surgery ☐ Particular bleed

a. List body part:_____ **b.** Circle location of bleed →

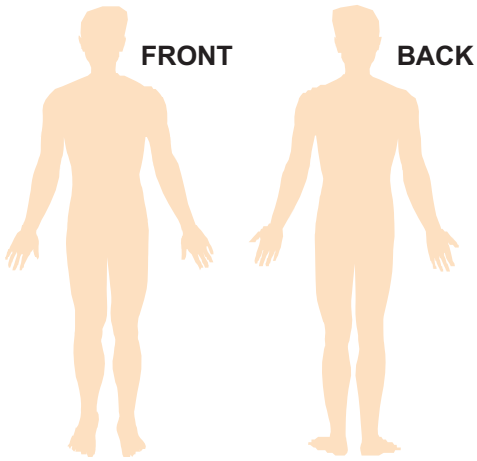
☐ Prevention/on-demand

☐ Bulk shipment for camp (request at least 3 months in advance)

☐ Emergency reserves (societies and HTCs only)

☐ Other: _____

Circle location of bleed



Type of factor concentrate requested: ☐ VIII ☐ IX ☐Other _____

Assay size needed: ☐ 250 IUs_____ ☐ 500 IUs_____ ☐ 1000 IUs_____

Total IUs needed: _____

Is your hemophilia society registered with the World Federation of Hemophilia? ☐ Yes ☐ No

I declare that the above information is true to the best of my knowledge. I will take full responsibility to ensure that this medicine is used only for the patient and medical situation listed above. I will complete and return Save One Life's documentation as stated in its Factor Donation Policy.

X	
Signature of patient/family member (REQUIRED)	**Printed name (please print CLEARLY)**
X	
Signature of General Secretary or President, national hemophilia society (REQUIRED)	**Printed name (please print CLEARLY)**
X	
Signature of attending physician from page one (REQUIRED)	**Printed name (please print CLEARLY)**

DISCLAIMER: Save One Life, Inc. is providing donated factor for the above patient only and in response to said patient's request. Save One Life's sole role in this process is assist with the delivery of the donated factor to the named patient requesting said factor. The donated factor concentrate is to be used only as provided for by the manufacturer and only to treat extended bleeding due to the medical condition of hemophilia or von Willebrand Disease. The factor is not intended for resale or for uses not intended by the manufacturer and is made available to assist with controlling bleeding in the above identified patient. Save One Life, Inc. is not responsible for lost, stolen or misplaced product or the manufacture of the product. Save One Life, Inc is not responsible for the condition of the product nor the suitability of the product. Save One Life, Inc. does not guarantee that more product will be donated after the above donation is shipped. The manufacturer of the product may not be aware of this shipment.