

Bleeding disorders treatment log



Dosage information	Bleed locations		Reason for treatment
	Key location(s)	Other location(s)	
Date	<input type="checkbox"/> Head	<input type="checkbox"/> Mouth	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Surgery <input type="checkbox"/> Physical therapy <input type="checkbox"/> Injury <input type="checkbox"/> Preventative infusion <input type="checkbox"/> Spontaneous bleed
Time	<input type="checkbox"/> Stomach	<input type="checkbox"/> Thigh	
Factor	L R	<input type="checkbox"/> GI	
	Hand	<input type="checkbox"/> Upper arm	
	Elbow	<input type="checkbox"/> Lower arm	
Lot #	Shoulder	Other_____	
	Hip		
	Knee		
Dose	Ankle		
	Foot		
RICE used: <input type="checkbox"/> Rest <input type="checkbox"/> Ice <input type="checkbox"/> Compression <input type="checkbox"/> Elevation		Missed work or school? <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, how many days? Work _____ School _____	
Comments			

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