

The Central California Bleeding Disorders Foundation (CCBDF) is offering medical ID bracelets or necklaces at no charge to the community. The company providing these emblems is American Medical ID. There are several choices pictured on the attached forms for patients to choose from and extra items that are printed or engraved in addition to the bracelets/necklaces. We no longer monetarily support the Medic Alert choice, but patients can certainly opt to use that company if they choose. The patient will need to cover the cost themselves.

There are three criteria for receiving this service:

1. Patient must have an inherited bleeding disorder

2. Patients must live in the 27 counties CCBDF serves. (The 27 counties that CCBDF serves are: Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Lassen, Madera, Mariposa, Merced, Modoc, Mono, Nevada, Placer, Plumas, Sacramento, San Joaquin, Shasta, Sierra, Siskiyou, Stanislaus, Sutter, Tehama, Tuolumne, Yolo, and Yuba.)

3. Patients must be listed in the CCBDF database as part of the CCBDF community. The CCBDF database is used to notify patients/families of services, programs, product information, events, scholarship, tutoring, emergency assistance, lifelong learning, and Spanish speaking programs. This information is never shared or sold to pharmaceutical companies or homecare companies. (A form is attached that needs to be filled out if the patient is not in the CCBDF database.)

It is strongly suggested that patients utilize the program nurse or social worker in filling out the American Medical ID form to be sure information is included that would be beneficial in case of an emergency.

Upon completing the forms, please email them to Stephanie Hill at stephanie@cchfsac.org and she will forward to American Medical ID.

If you have questions, you can email Stephanie or call her at 916-448-0370.

Sincerely, Stephanie Hill Executive Director, CCBDF

The Central California Bleeding Disorders Foundation exists to improve the quality of care and life for persons impacted by hemophilia and other inherited bleeding disorders through education, advocacy and support.

P.O. Box 163689 · Sacramento, CA 95816-9689 · 916-448-0370 www.cchfsac.org · info@cchfsac.org





## Instructions:

- **1.** Complete all necessary/applicable information on the first page of this form (below).
- 2. Proceed to the next page and select your desired medical ID style, size and color if applicable.

**3.** Complete the desired engraving information by typing directly onto the form or writing it in with a dark pen.

**4.** Please consider the allotted character limit for each line of space on the medical ID and note this includes spaces.

- 5. Submit the form via the instructions below.
- 6. Submit forms to Stephanie Hill at stephanie@cchfsac.org.

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## PATIENT REFERRAL FORM

CCBDF is a community-based, nonprofit organization that provides programs, activities and services—both fun and educational—to people with bleeding disorders in 27 counties of Northern California. Services range from scholarships to emergency financial assistance as well as all manner of educational programs that enable people to manage their condition and advocate for themselves. Details of CCBDF's various programs and services can be found on the CCBDF website (www.ccbdf.org).

The purpose of this form is to help introduce new patients and their families/caregivers to CCBDF, and vice versa. By providing the information requested below, you can help CCBDF understand your needs so that we can better serve you. Please provide all the information requested and then sign at the bottom, giving consent for your referring provider to send us this form.

All information received will be kept confidential and will be used only for the purpose of keeping you informed about CCBDF programs and services. We do not share our patient list.

Patient's Name:	Date of Birth:				
Parent's/Guardian's Name(s):					
Address:					
City/State/Zip Code:					
Home Phone:	Cell Phone:				
Email Address:	Gender: M F Decline				
Diagnosis: Hemophilia A (F-VIII) von Willebrand	Hemophilia B (F-IX) _ Other: (Please Specify)				
	ther: (Please Specify)				
Date of Referral: Referred b	y: Phone:				
Patient/Parent of Guardian's Signature Approv	ring Release of Above Information to CCBDF				
x					
(Please sign and date)					

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Complete and submit forms as instructed on page one. Your order will include the MyIHR QR Access Card.

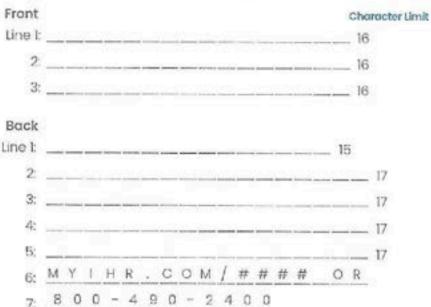
Patient First & Last Name (Required)

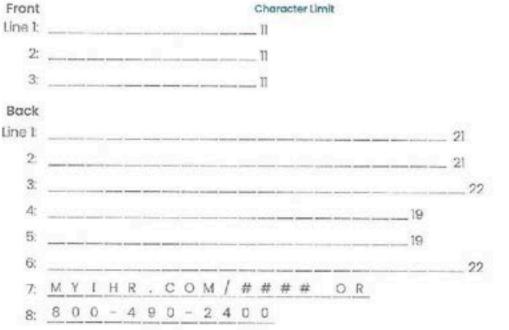
Patient Birth Date

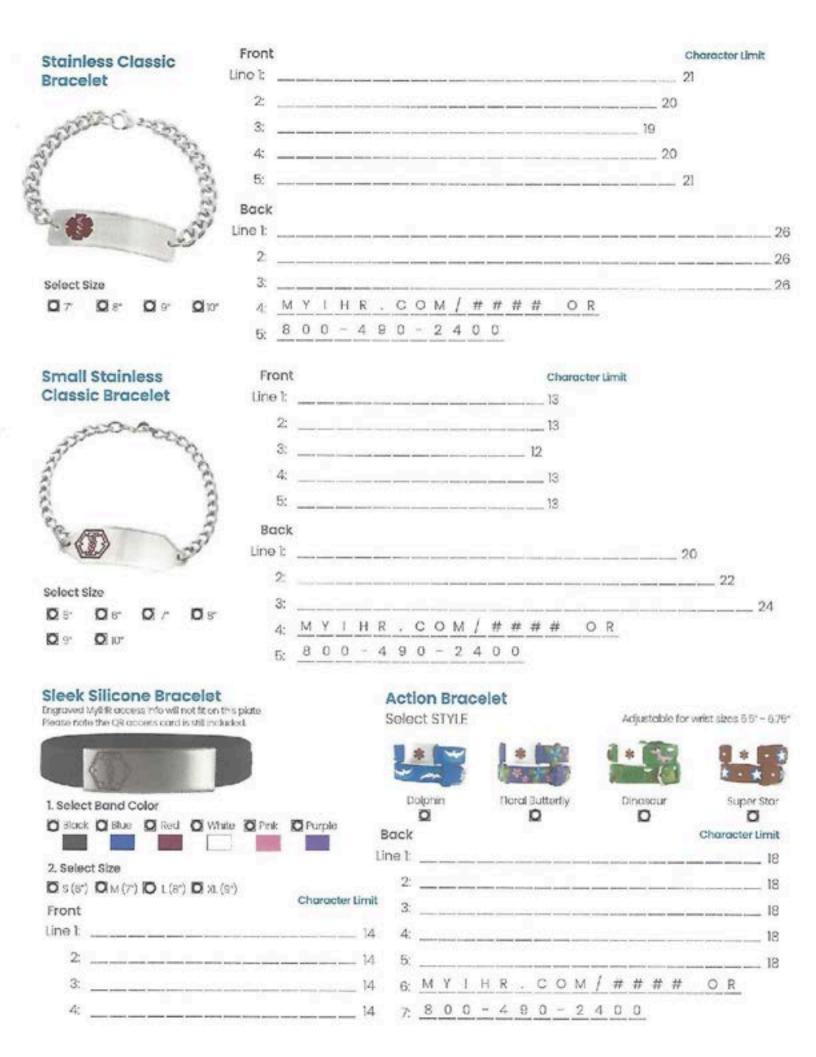
Patient Address (Required)			Parent / Guardian	Email
City	State	Zip	HTC or Hernatologist	Phone Number
Patient/Guardian Phone (Regulard)			Parent/Guardian Signature	

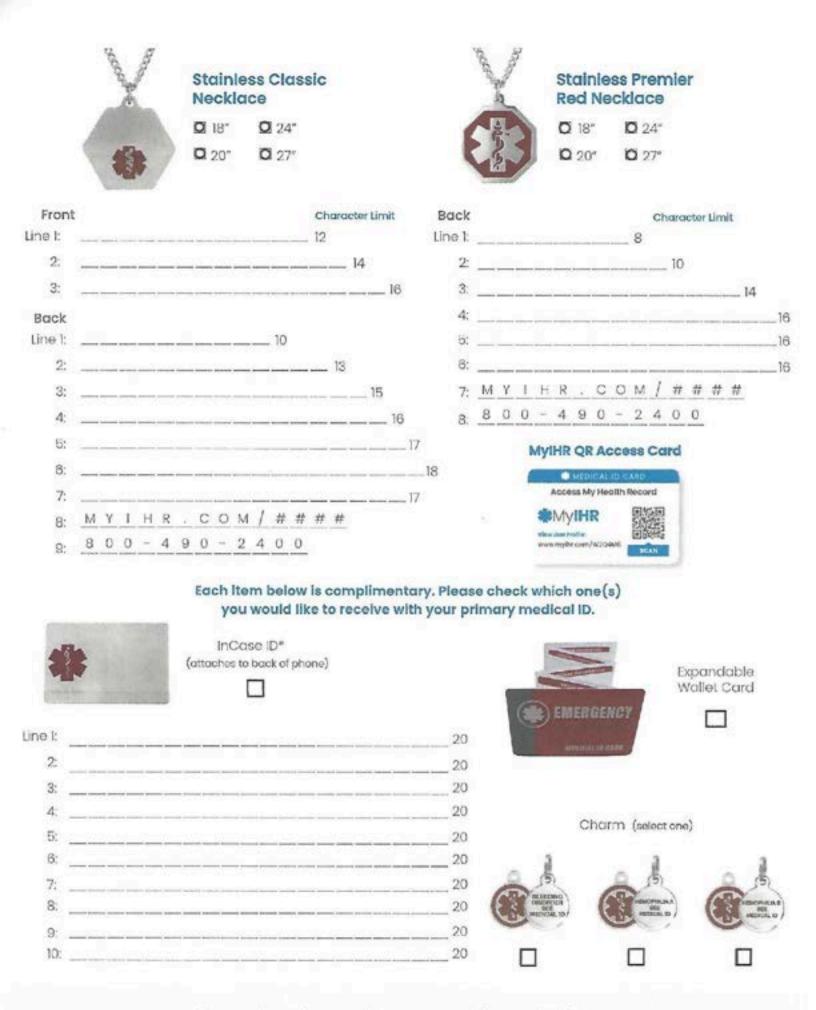
## ENGRAVING NOTE: Do not exceed character limits listed by line. Remember to include spaces between words.











For questions please email support@americanmedical-id.com