



THE BLOOD CENTER

Serving you for life!

REQUEST FOR THERAPEUTIC PHLEBOTOMY

To download this form, visit TheBloodCenter.org/Therapeutics

Incomplete forms are not accepted. Request expires 1 (one) year from date of signature.

Please call or fax form to your most local donor center:

Hammond:

(985) 340-2320 Phone
(985) 340-2330 Fax

Thibodaux:

(985) 447-1774 Phone
(985) 447-4093 Fax

Slidell:

(985) 641-4400 Phone
(985) 641-0785 Fax

Metairie:

(504) 249-4450 Phone
(504) 249-4451 Fax

Mandeville:

(985) 377-7007 Phone
(985) 377-7008 Fax

WestBank- Harvey:

(504) 263-1190 Phone
(504) 263-1196 Fax

PATIENT INFORMATION

Full Legal Name: _____

Date of Birth: _____

Telephone: _____

DIAGNOSIS-REASON FOR PHLEBOTOMY

- Secondary Polycythemia due to Testosterone Replacement Therapy **D75.1**
- Secondary Polycythemia, other **D75.1**
- Polycythemia Vera **D45**

- Hereditary Hemochromatosis **E83.110**
- Other Hemochromatosis **E83.118**
- Unspecified Hemochromatosis **E83.119**
- Other *(Include both ICD-10 Code and Diagnosis)*

MINIMUM HEMATOCRIT FOR PHLEBOTOMY

- FOR Polycythemia**
- 45%
 - Other: _____

- FOR Iron unloading (Hemochromatosis)**
- 33% (minimum)
 - Other: _____

HCT will be performed before each phlebotomy. No CBC or ferritin testing provided.

FREQUENCY (Whole Blood 500 +/- 50 mL)

Required:

- One time ONLY **OR** Every ____ week(s)

Optional: Hold collections after ____ # of collections - Request will expire once filled

PATIENT HISTORY

Does your patient have any medical contraindications or risks for phlebotomy?

- No
- Yes (If yes, explain)

PHYSICIAN INFORMATION (ALL FIELDS ARE MANDATORY)

Physician's Signature: _____

Printed Name: _____

Date: _____

Telephone: _____

Fax: _____