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 once the designated frequency is met.

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

Hammond:
(985) 340-2320 Phone
(985) 340-2330 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

Ocean Springs:
(228) 497-7160 Phone
(228) 497-7159 Fax

Thibodaux:
(985) 447-1774 Phone
(985) 492-5012 Fax

Slidell:
(985) 641-4400 Phone
(985) 641-0785 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)*

HEMATOCRIT/ HEMOGLOBIN FOR PHLEBOTOMY

Minimum Threshold:

_____

Maximum Threshold:

_____

HCT/HGB 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: _____