



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
(504) 910-8402 Fax

Ocean Springs:

(228) 497-7160 Phone
(228) 497-7159 Fax

Metairie:

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

Thibodaux:

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

Mandeville:

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

Slidell:

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

WestBank- Harvey:

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

New Orleans at UNO:

(504) 509-6292 Phone
(504) 509-7391 Fax

Picayune:

(601) 798-9693 Phone
(601) 799-3279 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
Do not draw if < than:

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) **OR** Other _____

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

PATIENT HISTORY

Does your patient have any medical contraindications or risks for phlebotomy that would prevent the use of the patient's blood?

- No Yes (If yes, explain)

PHYSICIAN INFORMATION (ALL FIELDS ARE MANDATORY)

Physician's Signature: _____

Printed Name: _____

Date: _____

Telephone: _____

Fax: _____