

Request for Therapeutic Phlebotomy

Important Information:

Therapeutic patients will only be drawn on **Tuesdays, Wednesdays and Thursdays** unless they are approved testosterone replacement or hereditary hemochromatosis donors.

Fax orders to (713) 790-1782 at least 72 hours prior to collection to allow time for review, Medical Director approval and data entry. Before coming in, new patients should call (713) 791-6608 to verify order receipt/entry.

Discuss frequency with your patient. Incomplete orders are not accepted. Order expires two (2) years from physician signature date.

Patient's Full Legal Name:		Date of Birth:
Full Mailing Address:		Telephone #:
		SSN: XXX – XX – (Last 4 digits only)
Diagnosis	<input type="checkbox"/> D75.1 Secondary Polycythemia due to Testosterone Replacement Therapy	<input type="checkbox"/> E83.110 Hereditary Hemochromatosis
	<input type="checkbox"/> D75.1 Secondary Polycythemia	<input type="checkbox"/> E83.118 Other Hemochromatosis
	<input type="checkbox"/> D45 Polycythemia Vera	<input type="checkbox"/> Other (Include both ICD-10 Code and Diagnosis):
Patient History	Does this patient have any medical contraindications for this procedure? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, explain)	
Minimum Hematocrit for Phlebotomy	<input type="checkbox"/> 32% (minimum)	Prior to each phlebotomy, the hematocrit will be measured. We do not perform CBC or ferritin testing.
	<input type="checkbox"/> Other: _____	

Physician Information (all fields are mandatory):

I request the above patient have a therapeutic phlebotomy of approximately 500 mL performed.	
Physician's Signature:	Date:
Printed Name:	Telephone #:
Full Mailing Address:	Fax #:

FAX COMPLETED REQUEST TO 713-790-1782 at least 72 HOURS PRIOR TO DONATION

Please call (713) 791-6608 with questions. To download this form visit www.giveblood.org.

OFFICE USE ONLY	
Deferral entry required? <input type="checkbox"/> Yes <input type="checkbox"/> No Reason:	
Deferral entry (if required), initials/date:	
SafeTrace ID:	MD Approval/Date: