Request for Therapeutic Phlebotomy

FAX COMPLETED REQUEST TO (713) 790-1782 or (832) 930-4888

For questions, call **(713) 791-6608**. To download this form, visit **https://www.giveblood.org/TherapeuticForm/**

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

HH and TRT patients being drawn ≥8 weeks apart *DO NOT* need a prescription if they meet allogeneic eligibility.

First:	Middle:	Last:
Full Mailing Address:		Date of Birth:
		Telephone #:
		SSN (Last 4 digits only): XXX–XX–

All patients must call (713) 791-6608 to verify order receipt before presenting at a location to be drawn.

Please allow up to 3 business days for processing.

Diagnosis - Reason for Phlebotomy	☐ **Testosterone Replacement Therapy** with Secondary Polycythemia (TRT) D75.1 ☐ **Hereditary Hemochromatosis** (HH) E83.110 ☐ Other *(Include ICD-10 Code and Diagnosis)*:
Minimum Hematocrit for Phlebotomy	Do not perform phlebotomy if hematocrit is below %. Minimum is 33%. **HCT will be performed before each phlebotomy. No CBC or ferritin testing provided. GCRBC is unable to accommodate any requests for collection volumes outside +/- 500 mL.**
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	If your patient has any medical contraindications or risks for phlebotomy, please indicate below. ☐ Anticoagulant Medication ☐ Heart Disease/Condition ☐ Neurological Disease/Condition ☐ Communicable Disease ☐ Other ☐ None

Ordering Physician Information (all fields are mandatory):

Physician Printed Name **(Required)**:	NP/PA Printed Name (if applicable):
Signature of Physician or NP/PA:	Date:
Full Mailing Address:	Telephone #:
	Fax #:

GCRBC Medical Services USE ONLY

Approval required? ☐ Yes ☐ No	MD/Designee Approval/Date:
e-Delphyn ID:	Completed by/Date: