Request for Therapeutic Phlebotomy

FAX REQUEST TO: (832) 930-4888. For questions, call **(713) 791-6608**.

Incomplete forms are not accepted. Request is valid for one (1) year.

- HH and TRT patients being drawn ≥8 weeks apart *DO NOT* need a prescription if they meet allogeneic eligibility.
- It is the responsibility of the patient to call **(713) 791-6608** and verify their order has been processed before scheduling an appointment or presenting at location to be drawn.
- No CBC or ferritin testing provided.
- GCB will only draw standard whole blood units of 500 mL, +/-50mL.

Full Legal Name (as it appears on ID)

First: Middle Initial: Last:

Full Mailing Address			Date of Birth:
Street:			Telephone #:
City:	State:	Zip:	SSN (Last 4 digits only): XXX–XX–

Diagnosis - Reason for Phlebotomy	☐ **Testosterone Replacement Therapy** with Secondary Polycythemia (TRT) D75.1 ☐ **Hereditary Hemochromatosis** (HH) E83.110 ☐ **Other** – ICD-10 Code: _____ Diagnosis: _____**(both are required)**
Minimum Hemoglobin (Hgb) for Phlebotomy	Do not perform phlebotomy if hemoglobin is below _____g/dL. **(Whole Numbers Only)** **GCB cannot accept a minimum Hgb below 11 g/dL or above 17 g/dL.** **Depending on testing availability, hemoglobin may be converted to hematocrit for eligibility determination.**
Frequency	Required: ☐ One time ONLY *Or* ☐ Every _____ week(s)
	Optional: ☐ Hold collections after _____ # of collections - Request will expire once filled.

Known Communicable Disease (HIV, HCV, HBV, etc.): **YES** ☐ **NO** ☐

Ordering Provider Information and Acknowledgement

By signing below, ***the treating provider confirms*** they are authorized to practice in Texas, and the patient will be able to tolerate therapeutic phlebotomy procedure(s).Furthermore, the patient does not have any medical contraindications for blood draws. The risks and benefits of therapeutic phlebotomies have been discussed with the patient.

Medical Doctor (required) Printed Name:			**NP/PA** (if applicable) Printed Name:
Signature of MD or NP/PA:			Date:
Full Mailing Address Street:			Telephone: Fax:
City	State	Zip	E-mail:

GCB Medical Services USE ONLY

e-Delphyn ID:	Completed by/Date: