Print

# Request for Therapeutic Phlebotomy

DS-SPDON-F-004 Rev 13

705 E 4th St Chattanooga, TN 37403
Phone # (423) 756-0966 Ext. 1188 or (423) 752-5959 Fax # (423) 752-8484
Email: specialdonations@bloodassurance.org
Attn: Special and Therapeutic Donations

**This order is valid for 1 year. If order is incomplete, donor will not be drawn.**

**Patient Information:** **BA id#:_____**

☐ Male ☐ Female **First name:** _____ **MI:**_____ **Last name:** _____

**Address:** _____
**City** **State** **Zip Code**

**Date of Birth:** _____ **Phone number:** _____

**Diagnosis creating need for phlebotomy (check all that apply):**

**Date of Diagnosis** _____

☐ Hereditary Hemochromatosis (HH). ☐ Polycythemia due to other causes

☐ Polycythemia due to Testosterone Therapy ☐ Other (specify) _____

In accordance with FDA regulations, only units from donors with hereditary hemochromatosis or testosterone induced polycythemia are transfusable.

**Predonation hgb: 12.5 g/dL for Females, 13.0 g/dL for Males (default).**
If different amount requested, please specify _____ g/dL.

Minimum Hemoglobin must be ≥ 11.0 g/dL. Phlebotomy has poor efficacy in iron removal if the hemoglobin is < 11 g/dL. If exception to draw donor at hemoglobin < 11 g/dL is requested, please provide ferritin level:

Date of sample collection _____ Ferritin result_____ ng/mL

**Frequency of Phlebotomies:** ☐ One time only ☐ Weekly ☐ Monthly ☐ PRN ☐ Other (specify) _____

For the donor's safety, a minimum of 4 days must elapse between donations.

**Volume: 1 unit which is 500 mL of whole blood (default).** If a smaller volume is requested, then specify _____ mL.

* Pre-donation hgb results will be released to physician as requested

**Attending Physician Printed Name:** _____

**Nurse Practitioner (NP) Printed Name (if applicable):** _____
If signed by a nurse practitioner, the printed name of the attending physician is required.

**Phone #:**_____ **FAX #** _____ **Office contact** _____

_____ _____ _____
**Signature of Attending Physician or NP** **E-Signature requires State License #** **Date**

**To Be Completed By Blood Assurance:**

Comments and/or Instructions: _____

_____ _____ _____
Signed Date **Order Expiration Date**

☐ **N300** Usable ☐ **N350** Usable ☐ **T934** Non-usable ☐ **T935** Non-Usable ☐ **Additional MedCodes:** _____