Therapeutic Phlebotomy Order

LifeSouth Community Blood Centers

Physician Instructions:

1. Complete, sign, and return this form to the blood center prior to the phlebotomy; physicians should not write prescriptions for themselves or immediate family members. **Complete all fields to avoid delays.**
2. Patient must have normal vital signs and be in otherwise healthy and stable condition for the request to be approved.
3. For standing orders, indicate the frequency of the donation and the hemoglobin limit. Note that the blood center can only determine hemoglobin values. **Monitoring of other values (ferritin, etc.) must be done at the doctor's office.** Standing orders expire one year from the request date.

Patient Information

Last Name:	First Name:	Middle Name:
Street Address:		Last 4 Digits of SSN:
City:	State:	Zip:
Phone:	DOB:	Sex:

Does the patient have a medical condition that may increase risk of adverse reaction and require medical supervision during phlebotomy?

☐ No ☐ Yes, explain: _____

Indication for phlebotomy:

- ☐ 238.4/D45 Polycythemia Vera (Primary)
- ☐ 289.0/D57.1 Polycythemia or Erythrocytosis, secondary
  - ☐ Testosterone Replacement Therapy (TRT)*
- ☐ 289.6/D75.0 Familial Polycythemia or Erythrocytosis
- ☐ 275.01/E83.110 Hereditary Hemochromatosis*
- ☐ 275.03/E83.118 Other Hemochromatosis (acquired) (liver) (myocardium) (secondary)
- ☐ 277.1/E80.1 Disorders of porphyrin metabolism (includes porphyria cutanea tarda)
- ☐ 790.6/R79.89 Other Abnormal Blood Chemistry (elevated ferritin, hemoglobin, iron)

***Note:** An additional acknowledgment is required for patients with **Hereditary Hemochromatosis** or **Secondary Polycythemia due to TRT**; instruct patient to complete the *Patient Acknowledgment* on page 2.

Order Details *(Each draw removes 500 mL ± 10% of whole blood.)*

Requested by (MD or RN) (print):

Phone:	Request Date:

Note: Patients with **Hereditary Hemochromatosis** or **Secondary Polycythemia due to TRT** may be evaluated for allogeneic donation. Qualified patients with sufficient hemoglobin levels could be accepted for allogeneic donation every eight weeks or as indicated below, whichever is more frequent.

Frequency of draw (select only one):

- ☐ One time only
- ☐ Once every _____ week(s)
- ☐ Once every _____ month(s)
- ☐ Other (specify): _____

Do not draw if hemoglobin level is less than: 12.5 g/dL g/dL

(Default minimum is 12.5 g/dL, if not specified.)

Requester's Signature:

Blood Center Use Only

☐ Approved ☐ Denied

Medical Director or designee: _____ Date: _____

Donor ID: _____

Fax Completed Form to 888-286-0179.

Patient Acknowledgment

LifeSouth Community Blood Centers

Note: *This acknowledgment is required for any patient diagnosed with Hereditary Hemochromatosis or Secondary Polycythemia due to Testosterone Replacement Therapy (TRT). The blood center will not perform a therapeutic phlebotomy on patients with the above conditions until the patient signs this form.*

I have been diagnosed with **(must check applicable diagnosis)**:

- ☐ Hereditary Hemochromatosis
- ☐ Secondary Polycythemia due to Testosterone Replacement Therapy

I understand that I will be treated as an allogeneic (volunteer) blood donor unless the blood center determines that I do not meet volunteer donor criteria. This means that at each collection, I will be asked the standard eligibility questions required of a volunteer blood donor and that the blood collected will be tested for infectious disease and possibly transfused to a patient.

I understand that if I **do not** meet standard donor criteria, my unit will be destroyed and I will be deferred as a volunteer blood donor. After such a deferral, I can continue to have blood drawn under a *Therapeutic Phlebotomy Order.*

I understand that I will not be charged a fee for the phlebotomy even if found to be ineligible as a volunteer blood donor.

I understand and agree to the statements above.

Name:	
Signature:	Date Signed:

Fax Completed Form to 888-286-0179.