Request for Phlebotomy for Prescription Testosterone Therapy

Original Contact Date:______________ MEDIC ID #:______________

(To Be Completed By the Attending Physician)

1. Patient Name:____

   Patient Address:____

   City:___________________________State:________________Zip:___________

2. Patient's DOB:____________ Age:____________ Phone #:______________________________

3. Indication for Phlebotomy:____

   ____

4. Indication for testosterone:

   ☐Replacement therapy (male) ☐Gender reassignment ☐Other:__________________________

5. Any major disease processes present:____

   ____

6. Any condition which would make the loss of 500 ml of blood dangerous? Yes_______ No_______

7. Current Medications:____

8. Current Hemoglobin:___________________________ Current Hematocrit:___________________________

9. Desired Hemoglobin:___________________________ Desired Hematocrit:___________________________

10. Other pertinent lab data:____

11. Number of Phlebotomies requested:___________________

12. Frequency of Phlebotomies:__________________________

13. Any additional Comments:____

Attending Physician Information:

Name:____

Address:____

Phone:____

____ __________________________

Attending Physician's Signature Date

(To Be Completed By Chief Medical Officer of MEDIC Regional Blood Center)

Patient acceptable for Therapeutic Phlebotomies: Yes_______ No_______

Comments and/or Instructions:____

____ __________________________

Signed, Chief Medical Officer of MEDIC Regional Blood Center Date