MEDIC
REGIONAL BLOOD CENTER

THERAPEUTIC PHLEBOTOMY REQUEST FORM

(This form **not** for use for Hereditary Hemochromatosis or Donors on 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. Diagnosis related to the indication for Therapeutic Phlebotomy:
   ☐Primary Polycythemia (Polycythemia Vera)
   ☐Secondary Polycythemia, Underlying disease:______________________
   ☐Porphyria Cutanea Tarda
   ☐Other:____

4. Other major disease processes present:______________________________

   ____

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

6. Current Medications:____

7. Current Hemoglobin:__________________ Current Hematocrit:__________________

8. Desired Hemoglobin:__________________ Desired Hematocrit:__________________

9. Other pertinent lab data:____

10. Number of Phlebotomies requested:___________________

11. Frequency of Phlebotomies:__________________________

12. 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

MEDIC Regional Blood Center
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Phone # 865-524-3074 FAX # 865-521-2644 Attention: Sr. Director of Donor Services