Prescription Testosterone Therapy Phlebotomy Request

MEDIC ID #:________________

Original Contact Date:______________

To Be Completed By the Attending Physician:

1. Patient Name:____Phone #: _________________

   Patient Address:____

   City:____State:________________________Zip:__________

2. Patient's DOB:______________________ Age:_______________ Gender: ☐ Male ☐ Female ☐ Transitioning

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