

# THERAPEUTIC DISCARD PHLEBOTOMY REQUEST

(This form not for use for Hereditary Hemochromatosis or Donors on Prescription Testosterone Therapy.)

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. 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  
1601 Ailor Avenue  
Knoxville, TN 37921

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