MEDIC
REGIONAL BLOOD CENTER

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

Phone # 865-524-3074 FAX # 865-521-2644 Attention: Donor Registration