



Hereditary Hemochromatosis 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. Basis for the diagnosis of Hemochromatosis:
 Genetic Studies Family History
 Serum Ferritin Level Other: _____

4. Has Primary Polycythemia (vera) been ruled out? Yes _____ No _____

5. Underlying disease present other than Hereditary Hemochromatosis: _____

6. Lab Studies: Serum Ferritin _____ Serum Iron _____ Transferrin Saturation % _____

7. Other pertinent lab data: _____

8. Current Medications: _____

9. Any condition which would make the loss of 500 ml of blood dangerous? Yes _____ No _____

10. Current Hct: _____ % Current Hgb: _____ gm

Desired Hct: _____ % Desired Hgb: _____ gm

11. Number of Phlebotomies requested: _____ 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 phlebotomy under the MEDIC Hereditary Hemochromatosis Protocol: 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

MEDIC 2.410B V4
09/27/2021