



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

MEDIC Regional Blood Center
1601 Ailor Avenue
Knoxville, TN 37921

MEDIC 2.410C V4
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