MEDIC
REGIONAL BLOOD CENTER

REQUEST FOR PHLEBOTOMY

MEDIC Donor ID #: _____

READ BEFORE COMPLETING THIS FORM:
This form should be completed by the treating physician for any patient/potential blood donor with Hereditary Hemochromatosis or testosterone therapy, when the physician expects the patient/donor may need to have blood collected more frequently than regulatory limits or expects that the donor may not meet allogeneic eligibility criteria.
Regulatory limits allow collection of one unit of Whole Blood (WB) every 56 days, or one Double RBC Pheresis every 112 days.
MEDIC's lowest limits for blood collection are a donor hemoglobin g/dL of 12.5 (Female) or 13.0 (Male).
Based upon the donor's qualifying information, and at MEDIC's discretion, a Whole Blood of approximately 500 mLs, or a double RBC pheresis, may be collected. Frequency of phlebotomy will be PRN/at MEDIC's discretion for approved phlebotomy requests. These donations will be used for transfusion unless the donor falls into a deferral category—those collections will be discarded.

Donors with conditions other than HH or testosterone therapy (such as obstructive sleep apnea, COPD, chronic smoking) will not be eligible for more frequent phlebotomy; however, they are eligible to be screened to donate at regular frequencies. This form is not needed for these conditions, and the donor will be deferred if they do not meet all eligibility criteria.
Persons diagnosed with Polycythemia Vera or Porphyria Cutanea Tarda should seek treatment with their diagnosing physician or other medical service.

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 ordering Phlebotomy:
   ☐ **Hereditary Hemochromatosis** ☐ **Testosterone Therapy**

4. Other major disease processes present:_____

   _____

5. Any reason known why this donor's blood products should not be transfused to another individual? No _____ Yes _____

   (if yes, specify): _____

6. Current Prescription Medication/s:_____

Attending Physician Information:

Name:_____

Address:_____

Phone:_____

_____ _____
Attending Physician's Signature Date

Send To: For Ailor Center -- phone # 865-524-3074/FAX # 865-521-2644; or For Farragut Center – phone # 865-671-0836/FAX # 865-675-1847

(To Be Completed By MEDIC Regional Blood Center):

Patient acceptable for Special Program:

Draw & Discard (Ther) phlebotomy: ☐
Hormone phlebotomy: ☐
Hereditary Hemochromatosis phlebotomy: ☐

☐ None – may be screened at regular allogenic frequency
☐ None – DEFER/ refer back to treating physician

Comments and/or Instructions:_____

Administrative Review: _____[* if "none" is marked for donor acceptability, notify physician office]

_____ _____
Signed, Chief Medical Officer of MEDIC Regional Blood Center Date

MEDIC Regional Blood Center
1601 Ailor Avenue
Knoxville, TN 37921