MEDIC
REGIONAL BLOOD CENTER

REQUEST FOR PHLEBOTOMY

MEDIC Donor ID #: _____

READ BEFORE COMPLETING THIS FORM:

This form should be completed by the treating healthcare provider for any patient/potential blood donor with Hereditary Hemochromatosis or testosterone therapy, when the healthcare provider 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, without any phlebotomy order from the provider.
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 accepted phlebotomy requests. These donations will be used for transfusion unless the donor falls into a deferral category; collections from deferrable donors 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 healthcare provider 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 Healthcare Provider Information:

Name:_____

Address:_____

Phone:_____

_____ _____
Attending Healthcare Provider'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):

(Administrative and Quality Review) ---Patient acceptable for Special Program:

Draw & Discard (Ther) phlebotomy: ☐ ☐ None – may be screened at regular allogenic frequency
Hormone phlebotomy: ☐ ☐ None – DEFER/ refer back to treating physician
Hereditary Hemochromatosis phlebotomy: ☐

(* if "none" is marked for donor acceptability, notify physician office]

	Review by	Date	Spec Inst add/verify	Deferral(s) add/verify
Administrative				
Quality				