

THERAPEUTIC PHLEBOTOMY ORDER FORM

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Patient Information

DONOR ID# _____

NAME:	Last, First, MI _____	DOB _____	Last 4 of SSN _____
Address:	_____		
DIAGNOSIS:	<input type="checkbox"/> Erythrocytosis; is this due to testosterone therapy? Yes ___ No ___ <input type="checkbox"/> Hereditary Hemochromatosis <input type="checkbox"/> Carrier of Hemochromatosis <input type="checkbox"/> Secondary Hemochromatosis <input type="checkbox"/> Porphyria Cutanea Tarda <input type="checkbox"/> Polycythemia Vera <input type="checkbox"/> Other: _____		PHONE NUMBER: Home/Cell: _____ Work: _____

Phlebotomy Collection Order Details

Volume to be Collected: <input type="checkbox"/> 1 Unit (500ml) <input type="checkbox"/> Other: _____ ml	Frequency of collection: _____ for example: Q-weekly, Q-monthly, etc.			
Duration of Collection: <input type="checkbox"/> For 1 year <input type="checkbox"/> For 6 months <input type="checkbox"/> Other: _____	Do not phlebotomize if HCT is less than: _____ %			
Healthcare Provider Information: _____ <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">Printed Name of Healthcare Provider</td> <td style="width: 33%;">Healthcare Provider Signature</td> <td style="width: 33%;">Date</td> </tr> </table>		Printed Name of Healthcare Provider	Healthcare Provider Signature	Date
Printed Name of Healthcare Provider	Healthcare Provider Signature	Date		
<i>This patient's cardiovascular status is sufficiently stable to withstand therapeutic phlebotomy in an outpatient setting without monitoring. Marsh Regional Blood Center requires a new healthcare provider order at least annually.</i>				
Address: _____ _____ _____	Phone: _____ FAX: _____			

Patient Instructions & Consent

<p>INSTRUCTIONS: A written order for therapeutic phlebotomy MUST be obtained from the healthcare provider's office before the first procedure is performed, any time a recent order has expired <i>or at least once annually</i>. It is recommended that a well-balanced meal be eaten within 4 hours prior to visiting Marsh's donor centers.</p> <p>Consent:</p> <p>1. My healthcare provider has informed me that I need therapeutic phlebotomy in the interest of my health and proper medical care and has described the benefits and risks of therapeutic phlebotomy to me.</p> <p>2. I have read the Blood Donor Educational Material and I have had the opportunity to ask questions and withdraw from the therapeutic procedure. I consent to therapeutic phlebotomy.</p>	
_____ Patient Signature	Date: _____

Fax completed order forms to 423-408-7544.