Print

Request for Therapeutic Phlebotomy

DS-SPDON-F-004 Rev 15

705 E 4th St Chattanooga, TN 37403
Phone # (423) 756-0966 Ext. 1188 or (423) 752-8455 Fax # (423) 752-8484
Email: specialdonations@bloodassurance.org
Attn: Special and Therapeutic Donations

This order is valid for 1 year. *<u>All sections must be completed for order to be processed</u>*.

Patient Information: **BA id#:_____**

☐ Male ☐ Female **Legal First name:** _____ **MI:**_____ **Last name:** _____

Address: _____
City **State** **Zip Code**

Date of Birth: _____ **Phone number:** _____

Diagnosis and ICD-10 code creating need for phlebotomy (check all that apply):

Date of Diagnosis _____

☐ Hereditary Hemochromatosis (HH). E83.110 ☐ Polycythemia Vera D45

☐ Polycythemia due to Testosterone Therapy D75 ☐ Other (specify) _____

In accordance with FDA regulations, only units from patients with hereditary hemochromatosis or testosterone induced polycythemia are transfusable.

Predonation hgb: 12.5 g/dL for Females, 13.0 g/dL for Males (default).
If different amount requested, please specify _____ g/dL.

Minimum Hemoglobin must be ≥ 11.0 g/dL. Phlebotomy has poor efficacy in iron removal if the hemoglobin is < 11 g/dL. If exception to draw patient at hemoglobin < 11 g/dL is requested, please provide ferritin level:

Date of sample collection _____ Ferritin result_____ ng/mL

Frequency of Phlebotomies: ☐ One time only ☐ Weekly ☐ Monthly ☐ PRN ☐ Other (specify) _____

For the patient's safety, a minimum of 4 days must elapse between donations.

Volume: 450-550 mL of whole blood (based on patient's height and weight). If a smaller volume is requested, then specify _____ mL.*Pre-donation hgb results will be released to physician, as requested .

Attending Physician Printed Name: _____

Nurse Practitioner (NP) Printed Name (if applicable): _____
If signed by a nurse practitioner, the printed name of the attending physician is required.

Phone #:_____ **FAX #** _____ **Office contact** _____

_____ _____ _____
Signature of Attending Physician or NP **E-Signature requires State License #** **Date**

To Be Completed By Blood Assurance:

Comments and/or Instructions: _____

_____ _____ _____
Signed Date **Order Expiration Date**

☐ **N300** Usable ☐ **N350** Usable ☐ **T934** Non-usable ☐ **T935** Non-Usable ☐ **Additional MedCodes:** _____

☐ **C050** ☐ **C002** ☐ **C003**