Angel Mobile Health Services, LLC

Request for Therapeutic Phlebotomy

Important Information:
Therapeutic patients will only be drawn on ***Tuesdays, Wednesdays and Thursdays*** *unless they are approved testosterone replacement or hereditary hemochromatosis donors.*

Fax orders to (866) 506-8483 at least 72 hours prior to collection to allow time for review, Medical Director approval and data entry. Before coming in, new patients should call (972) 464-7476 to verify order receipt/entry.

Discuss frequency with your patient. Incomplete orders are not accepted. Order expires two (2) years from physician signature date.

Patient's Full Legal Name:		Date of Birth:
Full Mailing Address:		Telephone #:
		SSN: XXX – XX – (Last 4 digits only)
Diagnosis	☐ D75.1 Secondary Polycythemia due to **Testosterone Replacement Therapy**	☐ E83.110 Hereditary Hemochromatosis
	☐ D75.1 Secondary Polycythemia	☐ E83.118 Other Hemochromatosis
	☐ D45 Polycythemia Vera	☐ Other (Include both ICD-10 Code and Diagnosis):
Patient History	Does this patient have any medical contraindications for this procedure? ☐ **No** ☐ **Yes (If yes, explain)**	
Minimum Hematocrit for Phlebotomy	☐ 32% (minimum)	**Prior to each phlebotomy, the hematocrit will be measured. We do not perform CBC or ferritin testing.**
	☐ Other: _____	

Physician Information (all fields are mandatory):

I request the above patient have a therapeutic phlebotomy of approximately 500 mL performed.	
Physician's Signature:	Date:
Printed Name:	Telephone #:
Full Mailing Address:	Fax #:

FAX COMPLETED REQUEST TO 866-506-8483 **at least 72 HOURS PRIOR TO DONATION**
Please call (972-) 464-7476 with questions.

OFFICE USE ONLY	
Deferral entry required? ☐ Yes ☐ No Reason: Deferral entry (if required), initials/date:	
MD Approval/Date:	