



## 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)
<b>Diagnosis</b>	<input type="checkbox"/> D75.1 Secondary Polycythemia due to <b>Testosterone Replacement Therapy</b>	<input type="checkbox"/> E83.110 Hereditary Hemochromatosis
	<input type="checkbox"/> D75.1 Secondary Polycythemia	<input type="checkbox"/> E83.118 Other Hemochromatosis
	<input type="checkbox"/> D45 Polycythemia Vera	<input type="checkbox"/> Other (Include both ICD-10 Code and Diagnosis):
<b>Patient History</b>	Does this patient have any medical contraindications for this procedure? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, explain)	
<b>Minimum Hematocrit for Phlebotomy</b>	<input type="checkbox"/> 32% (minimum)	<b>Prior to each phlebotomy, the hematocrit will be measured. We do not perform CBC or ferritin testing.</b>
	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Reason:	
Deferral entry (if required), initials/date:	
MD Approval/Date:	