Request for Therapeutic Phlebotomy

FAX COMPLETED REQUEST TO (713) 790-1782

For questions, call (713) 791-6608. To download this form, visit **https://www.giveblood.org/TherapeuticForm/**

Incomplete forms are not accepted. Request expires two (2) years from date of signature.

Patient's Full Legal Name:	
Full Mailing Address:	Date of Birth:
	Telephone #:
	SSN (Last 4 digits only): XXX–XX–

All patients must call (713) 791-6608 to verify order receipt.

Please allow up to 3 business days for processing.

Diagnosis - Reason for Phlebotomy	☐ Secondary Polycythemia due to **Testosterone Replacement Therapy** D75.1 ☐ Secondary Polycythemia, other D75.1 ☐ Polycythemia Vera D45	☐ Hereditary Hemochromatosis E83.110 ☐ Other Hemochromatosis E83.118 ☐ Other *(Include both ICD-10 Code and Diagnosis)*:
Minimum Hematocrit for Phlebotomy	**FOR Polycythemia** ☐ 45% ☐ Other: _____	**FOR Iron unloading (Hemochromatosis)** ☐ 33% (minimum) ☐ Other: _____
	HCT will be performed before each phlebotomy. No CBC or ferritin testing provided	
Frequency (Whole Blood 500 +/- 50 mL)	Required: ☐ One time ONLY *Or* ☐ Every _____ week(s)	
	Optional: ☐ Hold collections after _____ # of collections - Request will expire once filled	
Patient History	Does your patient have any medical contraindications or risks for phlebotomy? ☐ **No** ☐ **Yes (If yes, explain)**	

Physician Information (all fields are mandatory):

Physician's Signature:	Date:
Printed Name:	Telephone #:
Full Mailing Address:	Fax #:

*Therapeutic patients will only be drawn on **Tuesdays, Wednesdays and Thursdays between 8:00 AM and 4:00 PM** unless they are approved testosterone replacement or hereditary hemochromatosis donors.*

Blood Center USE ONLY	
Deferral entry required? ☐ Yes ☐ No	Reason:
Deferral entry (if required), initials/date:	
e-Delphyn ID:	MD/Designee Approval/Date: