Center Information:

Therapeutic Phlebotomy Order

Notes and Instructions:

- Prescriptions are valid for a maximum of 12 months. Orders or modifications may require Vitalant MD approval or consultation.
- *Volume of collection may be adjusted based on donor's total blood volume or current medical condition.
- Donors may come in less frequently than but not more frequently than indicated below unless approved by Vitalant MD.
- Intervals written as a range will equate to the shorter timeframe, e.g., 4-6 weeks = 4 weeks and "PRN" will equate to 8 weeks.
- Regulations for providers vary by state; Vitalant will not honor out-of-state orders if not expressly permitted by state entities.
- Therapeutic phlebotomy fees may be applicable for therapeutic collections.
- Vitalant does not perform ferritin/CBC testing. No saline reinfusion is provided, except following double red cell collections.

Patient Name: _____ Sex: _____ Date of Birth: _____

Address: _____

Primary Phone: _____ Email Address: _____

List any medical conditions that could impact safety such as cardiac, vascular, or pulmonary disease or positive infectious diseases.

_____

Diagnosis

☐ Testosterone Therapy (TT) Hemochromatosis: ☐ Hereditary ☐ Non-Hereditary ☐ Porphyria Cutanea Tarda (PCT)

Polycythemia: ☐ Primary vera ☐ Secondary (e.g., smoking or altitude) ☐ Other: _____
(May require Vitalant/MD designee approval)

Hemoglobin Threshold

Draw at Hgb of at least _____ g/dl

(15.0 g/dl is recommended for TT patients to prevent iron store depletion; minimum Hgb allowed for other diagnoses is 11.0 g/dl)

Draw Volume

Whole Blood (WB) is Default: ☐ WB (500 mL*) ☐ WB ½ unit (250 mL) ☐ Double Red Cells (limited eligibility/availability; 112 day minimum interval)

Draw Frequency

☐ Weekly for _____ weeks (max. 4 wks) then maintenance of: _____ ☐ Monthly (4-wk intervals) ☐ Every 8 weeks or PRN ☐ Other (specify initial and/or maintenance therapy instructions): _____

Ordering Physician Information

Does provider have privileges in the state where the phlebotomy will be performed?

☐ Yes, has active license in state ☐ Yes, reciprocity is allowed through _____ state license ☐ No (draw will not be performed)

Physician Name: _____ Provider State and License #: _____

Physician Address: _____

Office Phone Number: _____ Office Fax Number: _____

Physician Signature/Date: _____ Name of Person Filling out Form: _____

(MD order valid for a maximum of one year or when the terms of the order expire, whichever comes first.)

Vitalant Use Only

Date Order Received: _____ Reviewer Signature/Date: _____

Valid through Date: _____ FMD Name/Date (if approval is needed): _____

Protocol Information

Donor ID: _____ ☐ Collect fee, if checked

Patient Number: _____ $ _____

First Protocol #: _____ EC/Date: _____

Subsequent Protocol Number(s)

Protocol #: _____ EC/Date: _____

Protocol #: _____ EC/Date: _____

Deferral

Deferral Code: ☐ 3900-Therapeutic Donor, added ☐ NA-HH/TT Donor EC/Date: _____

Center Information:

Patient Name: _____

Date of Birth: _____

Date	Procedure #	Comments