Center Information:

Therapeutic Phlebotomy Order

Patient Information

Name ______________________ Sex ________ Date of Birth ____________

Address ____

Home Phone ______________ Alternate Phone ______________

Diagnosis

Hemochromatosis, specify type: ☐ Hereditary ☐ Non-Hereditary ☐ Polycythemia due to Testosterone Therapy

☐ Polycythemia, Primary ☐ Polycythemia, Secondary ☐ Porphyria Cutanea Tarda

☐ Other, Specify ______________ (May require Vitalant/MD designee approval)

List any medical conditions that we should be made aware of:

Note: Other conditions may require additional information and Vitalant Physician approval.

Type of Phlebotomy

☐ Whole Blood (500 mL*) ☐ Whole Blood ½ unit (250 mL) ☐ Double Red Cells (if donor qualifies; otherwise, whole blood will be drawn)

* Volume may be adjusted by Vitalant based on patient weight.

Frequency and Duration of Phlebotomy (Must be a defined time period. "As needed" is not a defined timeframe.)

☐ One time only ☐ Weekly ☐ Every _____ weeks ☐ Monthly (4 week intervals) ☐ Other, specify ______________

Additional Instruction, if indicated

Total number of Procedures________ Number of months Therapeutic prescription is valid (Maximum 12 months) ____________

Minimum Hemoglobin

Do not permit phlebotomy if hemoglobin is below _______. Vitalant minimum is 11.0 for whole blood or 12.0 for double red cells.

Default will be 12.5 (female)/13.0 (male) whole blood or 13.3 for double red cells, if not specified.

- 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.

Ordering Physician Information

Physician signature ______________ Physician name ______________ Date ________

Office address ____

Office phone number ______________ Fax number ______________

Vitalant Use Only

Request approved signature ______________________ Date ____________

BSI MD/Designee signature ______________________ Date ____________

Protocol Information – Vitalant Use Only

Date Order Received ______________ Order Valid Through Date (Per MD order) ______________

Donor ID ________ First Protocol Number ________ Patient Number ________ Date ________ EC ______

Subsequent Protocol Number(s)

	Date	EC		Date	EC
	Date	EC		Date	EC
	Date	EC		Date	EC
	Date	EC		Date	EC

Deferral

☐ 3900, THERAPEUTIC DONOR, added ☐ NA – HH/TT donor EC/Date ______________

vitalant

Center Information:

Patient Name ______________________________

Date of Birth ______________

Date	Procedure #	Comments