Inland Northwest Blood Center

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 BSI/MD designee approval)

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

Note: Other conditions may require additional information and BSI 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 BSI based on patient weight.

Frequency and Duration of Phlebotomy

☐ 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 _____. BSI minimum is 11.0 for whole blood or 12.0 for double red cells.

Default will be 12.5 for whole blood or 13.3 for double red cells, if not specified.

- Therapeutic phlebotomy fees may be applicable for therapeutic collections.
- BSI 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 _____

BSI Use Only

Request approved signature _____ Date _____

BSI MD/Designee signature _____ Date _____

Protocol Information – BSI Use Only

Date Order Received _____ Order Valid Through Date (1 year from MD order date) _____

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

Deferral

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

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Date	Procedure #	Comments