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**PHYSICIAN REQUEST FOR THERAPEUTIC PHLEBOTOMY**

Fill out form & fax to: 815-965-8756

PLEASE PRINT & FILL OUT COMPLETELY.

**PATIENT INFORMATION:**

LAST NAME: \_\_\_\_\_

FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER(s): \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX: \_\_\_\_\_

**DIAGNOSIS:** \_\_\_\_\_

SIGNIFICANT HEALTH HISTORY OR CONDITIONS: \_\_\_\_\_

VOLUME OF BLOOD TO BE REMOVED: \_\_\_\_\_ MLS

NUMBER OF PROCEDURES: \_\_\_\_\_

FREQUENCY OF PROCEDURES: \_\_\_\_\_

LOWEST ACCEPTABLE HEMOGLOBIN FOR THERAPEUTIC PHLEBOTOMY: \_\_\_\_\_ gm/dL

ORDERING PHYSICIAN NAME (PLEASE PRINT)	OFFICE STREET ADDRESS
ORDERING PHYSICIAN SIGNATURE	CITY STATE
DATE	OFFICE PHONE
	OFFICE FAX

NF0108.387/02