Rock River Valley
BLOOD CENTER

PHYSICIAN REQUEST FOR THERAPEUTIC PHLEBOTOMY

PATIENT INFORMATION:

LAST NAME: ____________________________________FIRST NAME: ______________________ MI: _______

ADDRESS: ____

PHONE NUMBER(s): ____

DATE OF BIRTH: _____________________________ GENDER: ☐ MALE ☐ FEMALE

DIAGNOSIS: ☐ Hereditary Hemochromatosis ☐ Primary Polycythemia Rubra Vera ☐ Secondary Polycythemia
☐ Erythrocytosis ☐ Elevated Ferritin/Hemoglobin Level ☐ Other:__________________________

SIGNIFICANT HEALTH HISTORY OR CONDITIONS: ____

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PHLEBOTOMY ORDER (renewed annually):

PLEASE NOTE: Blood drawn from some patients may be transfusable if all FDA donation requirements are met. FDA hemoglobin requirements are: males 13.0 g/dL and females 12.5 g/dL.

MINIMUM PRESCRIBED HEMOGLOBIN FOR THERAPEUTIC PHLEBOTOMY: ______________ g/dL.
Phlebotomy will not be performed below this hemoglobin level.

FREQUENCY AND NUMBER OF PROCEDURES: (Example: Every 2 weeks for 12 total phlebotomies)

Perform phlebotomy every ________ circle: WEEK(s) / MONTH(s) for ___________ total number of phlebotomies.

Additional instructions:____

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____ ______________________________________
ORDERING MEDICAL PROFESSIONAL NAME (PLEASE PRINT) OFFICE STREET ADDRESS

____ ______________________________________
ORDERING MEDICAL PROFESSIONAL SIGNATURE CITY STATE

______________ _____________________________________ ______________________________________
DATE OFFICE PHONE OFFICE FAX

Please complete this form and return to RRVBC Special Services Department via email or fax.
Email: specialservices@rrvbc.org Fax: 815-965-8756

Rock River Valley Blood Center 419 N. 6th Street, Rockford, Illinois 61107 Phone 815-965-8751

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