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

ROCK RIVER VALLEY BLOOD CENTER ROCKFORD, ILLINOIS

419 North 6th Street Rockford, IL 61107 815.965.8751 Fax: 815.965.8756 rrvbc.org

Rock River Valley BLOOD CENTER

Straight From the Heart

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