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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

ROCK RIVER VALLEY BLOOD CENTER ROCKFORD, ILLINOIS