Diane Mortenson, RN, BS
Special Services Coordinator
Direct: 815-961-2340
E-mail: dmortenson@rrvbc.org

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