BBCS#:

Rock River Valley BLOOD CENTER
Straight From the Heart

PHYSICIAN REQUEST FOR THERAPEUTIC PHLEBOTOMY

Please complete this form and return to RRVBC Special Services Department via email: specialservices@rrvbc.org For questions, call 815-965-8751

Download this form here: https://www.rrvbc.org/donate/#donationtypes

Incomplete forms will not be accepted. Orders are valid for one year.

PATIENT INFORMATION

First Name: MI: Last Name:

Date of Birth: Telephone #:

Address:

City: State: Zip:

*** All patients must allow 3 business days for processing before calling 815-965-8751 for an appointment. ***

Diagnosis

RESET

- ○ Hereditary Hemochromatosis (hereditary/familial/genetic) *E83.110*
- ○ Polycythemia due to Testosterone Treatment *D75.1*
- ○ Primary Polycythemia/Polycythemia Rubra Vera *D45*
- ○ Other *(Include ICD-10 Code)*: _____

Minimum hemoglobin for phlebotomy

Do not perform phlebotomy if patient's Hgb is less than _____ g/dL.

CBC and Ferritin testing will not be provided. Hgb will be performed at phlebotomy.

Phlebotomy Order (whole blood 525 mL or based on patient weight)

RESET

- ○ One unit every _____ weeks.
- ○ One unit every _____ months.
- ○ One unit PRN for Hgb above _____ g/dL.

NOTE: One time only orders will not be accepted.

Health History
REQUIRED
(Additional space page 2.)

Please indicate patient medical conditions or risks for phlebotomy (if any) below.

- ☐ Cardiac disease/condition: _____
- ☐ Respiratory disease/condition: _____
- ☐ Neurological disease/condition: _____
- ☐ Recent hospitalizations: _____
- ☐ Communicable disease: _____
- ☐ Anticoagulation medication: _____
- ☐ Other: _____
- ☐ None

Ordering Medical Professional Name:

Ordering Medical Professional Signature: Date:

Office Address: City: State: Zip:

Office Telephone #: Office Fax #:

RRVBC Use Only

Donor Advocate Review: Date:

Medical Director Review: Date:

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Add additional medical history here:

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