Physician's Authorization for Therapeutic Phlebotomy

Patient Name:	Date of Birth:	Gender ☐ M ☐ F	Weight:
Address:	City & State	Zip	
Phone: Home ( )	Work ( )	Cell ( )	
Physician's Name (print)	Phone ( )	Fax: ( )	
Physician's Signature		Date:	

Indication for therapeutic phlebotomy:

☐ **Hereditary Hemochromatosis**

The above patient has been diagnosed with **Hereditary Hemochromatosis,** a genetic disease, and is being referred to Community Blood Center (CBC) for serial phlebotomies in order to deplete his/her iron stores, or maintain low iron stores. The patient understands that he/she will not be charged any fee for this service, but has agreed to donate the drawn blood for transfusion purposes if he/she meets all other allogeneic donor criteria (except frequency of donation).

☐ **Attach documentation of a genetic test to confirm diagnosis of Hereditary Hemochromatosis**

Patient must weigh 110lbs or more.

Reminder: ***It is the responsibility of the ordering physician to monitor the patient to determine appropriate frequency of phlebotomy. Donor must meet CBC requirements for blood pressure and pulse which will be performed on site before phlebotomy.***

Does patient have a diagnosis that puts him/her at risk for a phlebotomy complication (e.g., vasovagal response, hypotension, etc) ☐ **No** ☐ **Yes** If **Yes**, please explain:

Phlebotomy Requirements

Frequency and Duration:

Every: ☐ 1 week ☐ 2 weeks ☐ 3 weeks ☐ 4 weeks ☐ Monthly ☐ PRN

☐ Other, specify____

Hemoglobin: Phlebotomy will **not** be performed **if hemoglobin is less than** _______g/dL.
CBC minimum is 11.0g/dL. **Ferritin testing is not performed at CBC.**

Amount of Blood Drawn: **1 unit (approximately 500mL) will be** drawn per visit.

Specify if a lesser volume should be drawn:_______________________

Authorization Period: This authorization is valid for one year. ☐ Yes ☐ No

Specify time limit if authorization is for **less** than one year. ___________________

COMMUNITY BLOOD CENTER OFFICE USE ONLY:

CBCKC Physician Signature: **Date Approved:**

Fax completed form to Therapeutic Services 816-277-0785 Telephone: 816-968-4081