University Health

Therapeutic Phlebotomy Order

Please fax completed form to UHS Blood Donor Services: Fax Number- 210-358-4616; Phone Number- 210-358-2812

PATIENT INFORMATION

Name _____ Sex_____ Date of Birth _____
Address _____
Home Phone _____ Alternate Phone _____

Diagnosis

☐ Polycythemia due to Testosterone Therapy ☐ Polycythemia, Primary ☐Polycythemia, Secondary

Hemochromatosis, specify type: ☐ Hereditary ☐ Non-Hereditary ☐Porphyria Cutanea Tarda

☐ Other, Specify (May require UHS MD designee approval)

List any medical conditions that we should be made aware of:

Note: Other conditions may require additional information and UHS Physician approval.

TYPE OF PHLEBOTOMY

☐ Whole Blood (500 mL*) ☐ Whole Blood ½ unit (250 mL)

FREQUENCY AND DURATION OF PHLEBOTOMY

☐ One time only ☐ Weekly ☐ Every ___ weeks ☐ Monthly (4 week intervals) ☐ Other, specify_____

Additional Instruction, if indicated

Total number of Procedures _____

Number of months Therapeutic prescription is valid ____ (Maximum 12 months)

MINIMUM HEMOGLOBIN

Do not permit phlebotomy if hemoglobin is below _____ . UHS minimum is 11.0 for whole blood

- Therapeutic phlebotomy fees are applicable for therapeutic collections.
- UHS does not perform ferritin/CBC testing. No saline reinfusion is provided

ORDERING PHYSICIAN INFORMATION

Physician signature_____ Physician name _____ Date _____
Office address _____
Office phone number _____ Fax number _____

UHS USE ONLY

Date Order Received _____ Order Valid Through Date (1 year from MD order date) _____
Donor ID _____

UHS Transfusion Medicine Physician request approval:
"The patient's medical history, current vital signs, hemoglobin and physician's order was reviewed and there is no contraindication for therapeutic phlebotomy. The patient is be phlebotomized as detailed above.

UHS MD/Designee signature _____ Date_____