

Therapeutic Whole Blood Phlebotomy Request

General Information

- Patients **MUST** have an appointment
- Patients **MUST** have a written order prior to scheduling an appointment
- Call the Special Procedures Scheduling appointment line: **1-877-659-2001**
- Fax request to: **619-297-4064**
- Therapeutic orders are valid for 1 year unless otherwise specified
- Volume to be collected 500mL or 250mL
- Patient must have completed any antibiotic therapy prior to therapeutic appointment.
- Only medically stable patients will be drawn. Medically unstable patients, including patients with severe shortness of breath or severe heart conditions, cannot be drawn.

Patient Information (ALL Fields Mandatory)

Last Name	First (Legal) Name	Middle Initial	Suffix	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date (mm-dd-yy)
Parent/Guardian Name (If patient is a minor)		Address		City	State Zip
Primary Language	Weight	Phone Number ()			<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
		Alternate Phone Number ()			<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
Diagnosis/Condition (Mark all that apply)					
<input type="checkbox"/> Hereditary Hemochromatosis <input type="checkbox"/> Polycythemia Vera <input type="checkbox"/> Erythrocythemia <input type="checkbox"/> Taking Testosterone <input type="checkbox"/> Other: _____					

Phlebotomy Information (ALL Fields Mandatory)

Frequency <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Other: (See Comments)	Requested Volume (Required) <input type="checkbox"/> 250mL <input type="checkbox"/> 500mL	Target Hgb or HCT at or below which blood will not be drawn Note: Target Hgb of <11 g/dL must be cleared by the blood bank CMO prior to appointment. If no target Hgb/HCT is specified by the patients physician, the patient must meet the blood banks allogeneic criteria to be drawn. Target Hgb or HCT: _____
Comments / Special instructions or Precautions: (Required for all draws <500mL)		

Physician's Pre-Assessment of Patient: Please check for past or present medical conditions.

<input type="checkbox"/> Angina <input type="checkbox"/> Anticoagulant Therapy (Current) <input type="checkbox"/> Aortic / Subaortic Stenosis <input type="checkbox"/> Cardiomyopathy	<input type="checkbox"/> Cardiovascular Disease <input type="checkbox"/> CHF- Symptomatic <input type="checkbox"/> Recent MI (<6 months ago) <input type="checkbox"/> Recent Stent placement (<6 months ago)	<input type="checkbox"/> Seizures <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Strokes/TIA <input type="checkbox"/> Other: _____
Is patient capable of transferring to donation bed independently? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Additional Comments:		

Physician Information (ALL Fields Mandatory)

Physician Name (Please Print)	Office Phone Number ()	Fax Number ()
Office Email Address	Address	
<i>In my opinion, there are no medical findings that would preclude this patient from completing a Therapeutic WB procedure. I understand that the patient eligibility is subject to the blood bank CMO approval.</i>		
Physician Signature	Date	

Blood Bank use only:

Entered into Safe Trace by (Staff ID and Date):	Verified in Safe Trace by (Staff ID and Date):
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