

Request for Therapeutic Phlebotomy
 (Therapeutic patients must present completed copy at the time of phlebotomy.)

Patient Information

Full Name:	Date of Birth:
Address:	Telephone #:
	SS #: XXX - XX - (Last 4 digits only)
Diagnosis:	
Does this patient have a history of cardiovascular or pulmonary disease, hepatitis, HIV, stroke, or seizures? If yes, please explain.	
Minimum Desired Hematocrit:	% (Required)
Note: Gulf Coast will not draw donors when hematocrit is below 32%. Frequency of donations may change over time as hematocrit levels change. Please discuss desired frequency with your patient.	
Before a donation/phlebotomy can be performed, a hematocrit test will be performed.	
Patient will not be drawn below the minimum desired hematocrit.	

Physician Information

Name:	Telephone #:
Address:	Fax #:
I request the above patient donate blood/have a therapeutic phlebotomy performed. This person does not have any medical contraindications for this procedure. This request shall be valid for two years from the date it is signed.	
Physician's Signature:	Date:

FOR BLOOD CENTER USE ONLY

Donation Information	Method of Payment
Donor Center:	Check/Money Order #:
Unit #:	Medicare #:
Date:	<input type="checkbox"/> Hemochromatosis – No Charge
Hematocrit: %	Phlebotomist's Signature:
Blood Center's Medical Director/Designee Review:	