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(201) 444-3900 Fax (201 444-1885)

STAFF USE ONLY
Reviewed by _____
Date _____

Request for Phlebotomy – Hereditary Hemochromatosis

PATIENT INFORMATION – (PLEASE PRINT)

Name: _____ (LAST) _____ (FIRST)

Address: _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP CODE)

Home Phone _____ (AREA CODE & NUMBER) Business Phone _____ (AREA CODE & NUMBER)

Date of Birth: _____

Diagnosis; _____

MEDICAL ELIGIBILITY:

Some medical conditions may preclude donation. Final eligibility will be determined by the Blood Center’s Medical Director.

PHYSICIAN ‘S ORDER:

Frequency of Donation: _____

Minimum Hemoglobin Requirements: _____

This request shall be valid for one year from the date it is signed.

PHYSICIAN NAME: (please print) _____

ADDRESS: _____ (STREET) _____ CITY _____ STATE _____ ZIP CODE)

TELEPHONE: (_____) _____ FAX: (_____) _____

I consider this patient to be in good health and request Community Blood Services to collect therapeutic phlebotomy (ies) as directed above. I understand that Community Blood Services will only perform therapeutic phlebotomies from patients with Hereditary Hemochromatosis.

Physician Signature

Date