COMMUNITY BLOOD SERVICES
970 Linwood Avenue West Paramus, NJ 07652
(201) 444-3900 Fax (201) 444-1885

STAFF USE ONLY

Reviewed by _____

Date _____

Physician's Request for Phlebotomy – Hereditary Hemochromatosis

PATIENT INFORMATION – (PLEASE PRINT)

Name: _____ _____
(LAST) (FIRST)

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

Home Phone_____ Business Phone_____
(AREA CODE & NUMBER) (AREA CODE & NUMBER)

Date of Birth: _____

MEDICAL ELIGIBILITY:

*****Some medical conditions may preclude donation. The Blood Center's (CBS) Medical Director will determine final eligibility.

PHYSICIAN'S ORDER:

Diagnosis: _____

Frequency of Donation: _____

Minimum Hemoglobin Requirements: _____

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

PHYSICIAN'S 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's Signature **Date**

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Instructions for Physicians Request for Phlebotomy

Hereditary Hemochromatosis

PATIENT INFORMATION	
Donor's Name:	Verify donor's full name entered.
Donor's Address:	Verify donor's address entered in full.
Donor's Home Phone:	Verify Donor's telephone number entered.
Donor's Business Phone	Verify Donor's business number is entered.
Donor's Date of Birth:	Verify Donor's date of birth.
PHYSICIAN'S ORDER	
Diagnosis:	Verify Diagnosis of Hereditary Hemochromatosis.
➢ Frequency of Donation:	Verify frequency of donation is entered.
➢ Minimum Hemoglobin:	Verify hemoglobin entered.
Physician's Name:	Verify physician's name entered.
Physician's Address:	Verify physician's address entered.
Physician's Telephone:	Verify physician's telephone number entered.
Physician's Fax:	Verify physician's fax number entered.
Physician's Signature/Date:	Verify physician signature/dare are present.
Staff Use Only	Supervisor/Designee to initial and date review of form.