

Therapeutic Services

Physician's Authorization for Therapeutic Phlebotomy

Patient Name:	Date of Birth:	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Address:	City & State	Zip
Phone: Home ()	Work ()	Cell ()
Physician's Name (print)	Phone ()	Fax: ()
Physician's Signature		Date:

Diagnosis	<input type="checkbox"/> Hereditary Hemochromatosis The above patient has been diagnosed with Hereditary Hemochromatosis , a genetic disease, and is being referred to Community Blood Center (CBC) for serial phlebotomies in order to deplete his/her iron stores, or maintain low iron stores. The patient understands that he/she will not be charged any fee for this service, but has agreed to donate the drawn blood for transfusion purposes if he/she meets CBC's criteria. Furthermore, he/she has agreed that I provide the following laboratory information: Most recent ferritin value: _____ Test date: _____
	Ferritin testing is not performed at CBC <input type="checkbox"/> Secondary Hemochromatosis <input type="checkbox"/> Polycythemia <input type="checkbox"/> Testosterone Induced Polycythemia <input type="checkbox"/> Other:specify_____

Does patient have a diagnosis that puts him/her at risk for a phlebotomy complication (e.g., vasovagal response, hypotension, etc) **No** **Yes** If **Yes**, please explain:

Phlebotomy Requirements	Frequency and Duration: <input type="checkbox"/> One time only <input type="checkbox"/> Monthly <input type="checkbox"/> PRN <input type="checkbox"/> Every _____ weeks <input type="checkbox"/> Weekly; for total of _____ # phlebotomies; then specify frequency _____ <input type="checkbox"/> Other, specify _____
	Hemoglobin: Phlebotomy will not be performed if hemoglobin is less than _____g/dL. CBC minimum is 11.0g/dL. Amount of Blood Drawn: If the amount of blood drawn should not be in the 500mL \pm 50mL range (approximately 232mL RBC), specify the volume to draw: _____ Authorization Period: This authorization is valid for one year. <input type="checkbox"/> Yes <input type="checkbox"/> No Specify time limit if authorization is for less than one year. _____

CBC USE ONLY:**Physician Review:****Date Approved:****Fax completed form to Therapeutic Services 816-968-4416 Telephone: 816-968-4081**