Community Blood Center Administrative Offices: 4040 Main Street Kansas City, MO 64111

Therapeutic Services

Physician's Authorization for Therapeutic Phlebotomy

Patient Name:	Date of Birth:	Gender ☐ M ☐ F
Address:	City & State	Zip
Phone: Home ( )	Work ( )	Cell ( )
Physician's Name (print)	Phone ( )	Fax: ( )
Physician's Signature		Date:

Diagnosis

☐ **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

☐ Secondary Hemochromatosis ☐ Polycythemia

☐ Testosterone Induced Polycythemia

☐ 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:

☐ One time only ☐ Monthly ☐ PRN

☐ Every _____ weeks

☐ Weekly; for total of _____# phlebotomies; then specify frequency_____

☐ 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 ± 50mL range (approximately 232mL RBC), specify the volume to draw:_____

Authorization Period: This authorization is valid for one year. ☐ Yes ☐ 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