

**THERAPEUTIC PHLEBOTOMY PHYSICIAN ORDER**
**No self-scheduling or walk-ins accepted.**
**LifeStream will contact patient AFTER order received.**

<b>To the Physician:</b> Therapeutic phlebotomies are by prescription <u>and</u> appointment only • Fax completed orders to 909-386-6817 • For appointments and/or assistance contact Medical Services Department at 1-877-386-6874					
<b>Patient Information</b>					
Patient Legal Last Name		Patient Legal First Name			
Patient Address		Patient Date of Birth		Birth Sex (circle one) <b>M      F</b>	
Patient Phone Number		Patient Email			
<b>Physician Information</b> ( <i>must be MD/DO, ND, NP or PA and licensed in US</i> )					
Physician Name/Credentials		Physician Phone Number			
Physician Address		Physician Fax Number			
<b>Patient Diagnosis</b> (Check one)					
<i>Phlebotomy Fees are Waived for:</i>			<i>Phlebotomy Fees are Charged for:</i>		
<input type="checkbox"/>	Secondary Polycythemia ( <b>DUE</b> to testosterone therapy)		<input type="checkbox"/>	Primary Polycythemia (vera, other rare genetic polycythemas)	
<input type="checkbox"/>	Hereditary Hemochromatosis (confirmed by HFE C282Y mutation analysis or liver biopsy)		<input type="checkbox"/>	Secondary Polycythemia ( <b>NOT</b> due to testosterone therapy)	
			<input type="checkbox"/>	Iron Overload <b>NOT</b> hereditary hemochromatosis (transfusion, porphyria cutanea tarda, liver disease, etc.)	
			<input type="checkbox"/>	Other, specify:	
<b>Frequency of Phlebotomy</b> (Check one) <i>*if one is not checked, default will be every 56 days</i>					
<input type="checkbox"/>	One Time Only	<input type="checkbox"/>	Every 2 weeks	<input type="checkbox"/>	Every 8 weeks
<input type="checkbox"/>	Weekly	<input type="checkbox"/>	Every 4 weeks	<input type="checkbox"/>	Other:
<b>Minimum Hemoglobin</b> <i>*if minimum is not indicated, default will be 13 gm/dL</i> <i>(Note: Blood center does not perform ferritin or HCT% testing)</i> Do not perform phlebotomy if patient's Hemoglobin is less than: _____ g/dL					
<b>Phlebotomy Volume:</b> Approx. 500 mL of whole blood ( <i>volume may be adjusted based on patient's weight</i> )					
<b>Provider Signature</b> ( <i>Note: Requests with practitioner's name signed by another individual, initialed or with a stamped signature will be returned for authorized signature.</i> )					
<i>I have evaluated this patient and I am aware of no contraindications to this procedure. I have explained the reason for this procedure to the patient, including the fact that a fee may be charged directly to the patient by the blood center. I will be responsible for the patient's follow-up care. <b>With my signature I am confirming and verifying the diagnosis listed above.</b></i>					
<b>Provider Signature:</b> _____ <b>Date:</b> _____					
Reserved for LifeStream documentation only: Medical Director approval: <input type="checkbox"/> N/A <input type="checkbox"/> Required: _____ Date: _____ (Authorizing Medical Director Signature)					

***(PLEASE GIVE THE BELOW INFORMATION TO YOUR PATIENT)***

**IMPORTANT THINGS YOU SHOULD KNOW ABOUT YOUR THERAPEUTIC  
PHLEBOTOMY**

1. LifeStream's Medical Services Department will contact you **AFTER** we receive the order from your physician.
2. Walk-ins and self-scheduling **will not** be accepted for therapeutic phlebotomies.
3. Your Therapeutic phlebotomy appointments will take approximately one (1) hour at LifeStream's donor centers.
4. Please drink plenty of fluids and eat well before your appointment
5. If you have any questions regarding this process, please contact LifeStream's Medical Services Department at 1-877-386-6874.