LifeStream
GIVE HOPE | GIVE LIFE | GIVE BLOOD

THERAPEUTIC PHLEBOTOMY PHYSICIAN ORDER

Patient Information:

Name: _____ Date of Birth: _____

Address: _____

Primary Phone Number: _____ Secondary Phone Number: _____

- Phlebotomy fees are WAIVED for **ALL** patients with confirmed Hereditary Hemochromatosis or for Testosterone Replacement Therapy.
- Phlebotomy fees are charged for **ALL** OTHER DIAGNOSES.
- The blood center **DOES NOT** perform ferritin testing.

Diagnosis (PLEASE CHECK ONE)

☐ **Primary polycythemia** (Polycythemia vera, other rare genetic polycythemias)

☐ **Secondary polycythemia (due to testosterone therapy)**

☐ **Secondary polycythemia (not related to testosterone therapy)**

☐ **Hereditary Hemochromatosis** (Confirmed by *HFE* C282Y mutation analysis or liver biopsy)

☐ **Iron overload, not hereditary hemochromatosis** (transfusion, porphyria cutanea tarda, liver disease, etc.)

☐ **Other (Specify):** _____

Frequency:

☐ One time only ☐ Weekly ☐ Monthly (28-32days) ☐ Other: _____ **(If not specified, default is 56 days)**

Minimum Hemoglobin:

Do not permit phlebotomy if Hemoglobin gm/dL is less than _____gm/dL. **(Default if not specified will be 13gm/dL).**

Ordering Provider Information: (Provider MUST BE: MD/DO, NP or PA and must be indicated below)

Print Provider Name/credentials: _____

Address: _____ Phone Number: _____

_____ Fax Number: _____

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. **With my signature I am confirming and verifying the diagnosis listed above.**

Provider Signature: _____ Date: _____

(MUST be signed by provider / stamp or verbal order not accepted)

Please contact Medical Services for assistance at **1.877.386.6874** Fax completed form to **909.386.6817**

DO NOT WRITE BELOW THIS LINE – REVIEW RESERVED FOR LIFESTREAM MEDICAL DIRECTOR APPROVAL.

Verbal approval received on: _____ (Date) from _____ (Name of authorizing Medical Director) / _____ (Coordinator initials)

Review and approval by LifeStream Medical Director: _____ (Authorizing Medical Director Signature) Date: _____