LifeStream
GIVE HOPE | GIVE LIFE | GIVE BLOOD

THERAPEUTIC PHLEBOTOMY PHYSICIAN ORDER

To the Physician: Therapeutic phlebotomies are by prescription and appointment only

- Fax completed orders to 909-386-6817
- For appointments and/or assistance contact Medical Services Department at 1(877)386-6874

Patient Information

Patient Legal Last Name		Patient Legal First Name		
Patient Address		Patient Date of Birth		Birth Sex (circle one) **M** **F**
Patient Phone Number		Patient Email		

Physician Information (*must be MD/DO, NP or PA and licensed in US)*

Physician Name/Credentials		Physician Phone Number	
Physician Address		Physician Fax Number	

Patient Diagnosis (Check one)

Phlebotomy Fees are Waived for:		*Phlebotomy Fees are Charged for:*	
☐	Secondary Polycythemia (**DUE** to testosterone replacement	☐	Primary Polycythemia (vera, other rare genetic polycythemias)
☐	Hereditary Hemochromatosis (confirmed by HFE C282Y mutation analysis or liver biopsy)	☐	Secondary Polycythemia (**NOT** due to testosterone therapy)
		☐	Iron Overload **NOT** hereditary hemochromatosis (transfusion, porphyria cutanea tarda, liver disease, etc.)
		☐	Other, specify:

Frequency of Phlebotomy (Check one) **if one is not checked, default will be every 56 days*

☐	One Time Only	☐	Every 2 weeks	☐	Every 8 weeks
☐	Weekly	☐	Every 4 weeks	☐	Other:

Minimum Hemoglobin **if minimum is not indicated, default will be 13 gm/dL*

(Note: Blood center does not perform ferritin or HCT% testing)

Do not perform phlebotomy if patient's Hemoglobin is less than: _____**gm/dL**

Phlebotomy Volume: Approx. 500 mL of whole blood *(volume may be adjusted based on patient's weight)*

Provider Signature (*Note: Requests with practitioner's name signed by another individual, initialed or with a stamped signature will be returned for authorized signature.)*

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:**_____

Reserved for LifeStream documentation only:

Medical Director approval: ☐ N/A ☐ Required:_____Date:_____

(*Authorizing Medical Director Signature)*