LifeShare BLOOD CENTER

PHYSICIAN ORDER FOR THERAPEUTIC PHLEBOTOMY

*Orders must be submitted **72 hours** before the first collection to allow time for review and data entry*

PATIENT INFORMATION

Name _____ DOB _____ (mm/dd/yyyy)

Address _____ □ Male □ Female

_____ Telephone ( ) _____

_____ ( ) _____

DIAGNOSIS

Hemochromatosis	□ Hereditary	□ Non-hereditary
Polycythemia	□ Testosterone therapy	□ Vera
Other	Please explain _____	

□ ***Yes** □ **No** Does the patient have any medical conditions (e.g., heart, lung, or bleeding conditions) that could affect phlebotomy?)

**If Yes, a completed LifeShare Medical Release form from the patient's cardiologist/ Primary Care Physician (PCP) is required.*

Cardiologist/PCP _____ Phone ( ) _____

PHLEBOTOMY INSTRUCTIONS

Volume: 500 mL whole blood Please specify a different volume if one is necessary: _____ mL

Frequency: □ Weekly □ Every _____ weeks □ Monthly (28 day intervals)

The patient MUST call to make an appointment. This service is offered at specific times, on specific days, depending on location. For questions regarding the Therapeutic Phlebotomy Program, call (844) 370-9879.

MINIMUM HEMOGLOBIN (drawn via finger stick at phlebotomy)

Do not draw from the donor if the hemoglobin is below _____ g/dL

NOTE: LifeShare Blood Center does not perform, CBC, ferritin, or other tests

ORDERING PHYSICIAN INFORMATION

Orders will be valid for one year (12 months) from the date written below

Printed name _____ Signature _____ Date _____

Address _____ Telephone ( ) _____ Fax ( ) _____

_____

_____

_____

For any enquiries, please contact the

Special Donations Department @ (844) 370-9879
Fax Number: (318) 686-7751

FOR LIFESHARE BLOOD CENTER USE ONLY

Review_____ Date_____

Therapeutic prepayment required?
□ Yes □ No