# Therapeutic Phlebotomy Request

Ref: 03-04-01

Special Donations Department Tel: (650) 723-6667 FAX: (650) 723-8155

## PHYSICIAN ORDER FOR THERAPEUTIC PHLEBOTOMY:

**Patient Name**________________________________________ **Date of Birth:** _________________

**Patient Phone: Day:** __________________ **Eve:** ________________ **Cell:** ___________________

**Diagnosis (Reason for therapeutic phlebotomy):** _________________________________________

**ICD-9/10:**_______________________

*** **Notes**: - All therapeutic phlebotomy orders must be written by a physician, otherwise patients will not be accepted.

All patients must have appointments for phlebotomy. No walk-ins are accepted. *Instruct patient to call 650-723-6667 to schedule an appointment.*

COLLECT approximately __475 mL blood every ___________ week(s) X_________ TIMES.with a minimum

Hemoglobin of ________ **g/dL**

**Note:** Orders are valid for 12 months from the date signed.

***NOTE:*** *SBC will NOT collect blood from patients with* ***Hgb < 11.0 g/dL (Hct < 33%) by fingerstick evaluation at the time of presentation.***

**ADDITIONAL COMMENTS:** __________________________________________________________

_________________________________________________________________________________

**Physician Name (please print):** ____________________________________

**Physician Signature:** ______________________________________ **Date:** ____________________

**Physician Phone (Required):** ______________________ **Physician Fax (Required):**___________________

**Physician Address (Required):**____________________________________________________________

Stanford Blood Center Use Only:

| FOR BLOOD CENTER USE ONLY | |
|---|---|
| **Collect Prepayment? ❒Yes ❒No (list reason under exception) $** | |
| Exception: | |
| Comments: | |
| SD Initials: | Date: |
| Physician Contact Info. Verified by: | Date: |