

# THERAPEUTIC WHOLE BLOOD PHLEBOTOMY RECORD, REQUEST & CONSENT

## INFORMATION REQUIRED FOR ALL COLLECTIONS

\_\_\_\_\_  
Patient Name (Last) (First) (Middle Initial)

\_\_\_\_\_  
Date of Birth Donor Identification Number (DID#)

\_\_\_\_\_  
REQUESTING PHYSICIAN PRINTED NAME OFFICE NUMBER

Diagnosis: Hemochromatosis, Polycythemia Vera, Erythrocytosis, Other: \_\_\_\_\_  
(Circle One)

Amount to be collected: 250mls 500mls Other: \_\_\_\_\_mls  
(Circle One)

Frequency or # of Phlebotomies: \_\_\_\_\_ Minimum hemoglobin for Phlebotomy: \_\_\_\_\_ g/dL  
(3 day interval minimum)

\_\_\_\_\_  
Physician Signature Date Expiration Date: \_\_\_\_\_  
*Note: Prescriptions are valid for no more than 12 months.*

## THERAPEUTIC WHOLE BLOOD PHLEBOTOMY CONSENT

Therapeutic phlebotomy requires the removal of blood by venipuncture for medical reason(s). Due to your diagnosis, history and/or physical examination, your blood may not be used for transfusion and may be discarded. In the event that your blood is not used, disease testing will not be performed.

Prior to the phlebotomy, your blood pressure, pulse, temperature and hemoglobin will be checked.

I understand that on rare occasions medical complications may occur at time of donation and up to several days after donation. These include but are not limited to falling, fainting, bruising, swelling or numbness of the arm, or infection.

I have reviewed the donor instruction and have been given the opportunity to ask questions.

There may be a fee charged for this service that must be paid at the time of phlebotomy.

I understand the purpose and possible complications of a Therapeutic Phlebotomy. I have been provided the opportunity to ask questions. I consent to have my blood drawn for this purpose and understand this consent is valid for the duration of my physician's order, but not for more than a 12-month period.

\_\_\_\_\_  
Patient's Printed Name Patient/Guardian/Designee Signature Date

\_\_\_\_\_  
FBC Witness Signature Date

## SPECIAL CONSENT FOR HEMOCHROMATOSIS PATIENTS

There will be no charge for any hemochromatosis collections even if the patient does not qualify to be a routine blood donor after a history and physical examination. This applies to all patients with hemochromatosis, whether they are referred by a physician or are self-referred.

\_\_\_\_\_  
Patient's Signature Date FBC Witness Signature Date

