Memorial
BLOOD CENTERS
A Division of Innovative
Blood Resources

St. Paul
737 Pelham Blvd.
St. Paul, MN 55114
651-332-7321
Fax: 651-332-7001

Therapeutic Phlebotomy Order Form

It is the responsibility of the ordering licensed health care provider to monitor the patient to determine the appropriate frequency of phlebotomy.
Order expires every 12 months.
Individuals with hereditary hemochromatosis may be considered for allogeneic donation if eligible by all other allogeneic donor criteria (except frequency of donation).

PLEASE PROVIDE ALL REQUESTED INFORMATION

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

Indication for therapeutic phlebotomy:

☐ **HEREDITARY HEMOCHROMATOSIS**
Phlebotomy will not be performed if hemoglobin is less than 11.0 g/dL

☐ **Documentation of a genetic test to confirm the diagnosis of Hereditary Hemochromatosis**

1 unit (approximately 500 ML) shall be drawn every**:** _____ 1 week _____ 2 weeks _____4 weeks _____ 8 weeks _____ other

REMINDER: It is the responsibility of the ordering physician to monitor the patient to determine appropriate frequency of phlebotomy. Donor must meet MBC requirements for blood pressure and pulse which will be performed on site before phlebotomy.

Ordering Health Care Provider:

Name (print) _____ Telephone _____ Fax_____

Address: _____

Office contact name(s) for questions or clarifications _____

_____ _____
Provider's Signature **Date**

MBC Physician/Designee – Please sign and date once order form has been reviewed and approved

☐ Special Process Code and memo in SafeTrace
☐ Ok for allogeneic donation **if all criteria met**, other than donation interval.
☐ Therapeutic donation only. Donor has a deferral in BECS
☐ Order Expiration Date _____

MBC Physician/Designee Comments _____

_____

_____

_____ _____
Physician's Signature **Date**