



A member of the St. Joseph Hoag Health alliance

# Therapeutic Whole Blood Phlebotomy Request

## General Information

- Patients **MUST** have an appointment.
- Patients **MUST** have a written order prior to scheduling an appointment.
- Call the Special Procedures Scheduling appointment line: **(877) 659-2001**.
- Fax request to: **(619) 297- 4064**.
- Therapeutic orders are valid for 1 year unless otherwise specified.
- Volume to be collected - 500mL or 250mL
- Patient must have completed any antibiotic therapy prior to therapeutic appointment.
- Only medically stable patients will be drawn. Medically unstable patients, including patients with severe shortness of breath or severe heart conditions, cannot be drawn.

## Patient Information (ALL Fields Mandatory)

Last Name		First (Legal) Name		Middle Initial	Suffix	Gender <input type="checkbox"/> M <input type="checkbox"/> F		Birthdate (mm-dd-yyyy)	
Name of Parent/Legally Authorized Representative			Address			City	State	Zip	
State Relationship:									
Primary Language		Weight		Mobile Phone # ( )					
				Alternate Phone # ( ) <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other					
Diagnosis/Condition (Mark all that apply)									
<input type="checkbox"/> Hereditary Hemochromatosis <input type="checkbox"/> Polycythemia Vera <input type="checkbox"/> Erythrocythemia <input type="checkbox"/> Taking Testosterone <input type="checkbox"/> Other: _____									

## Phlebotomy Information (ALL Fields Mandatory)

<b>Frequency</b> <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Biweekly <input type="checkbox"/> Other: (See Comments)		<b>Requested Volume (Required)</b> <input type="checkbox"/> 250mL <input type="checkbox"/> 500mL	<b>Target hct at or below which blood will not be drawn</b> Target hct: _____ <b>Note:</b> Target hct of < 33% must be cleared by the blood bank CMO or designee prior to appointment. If no target hct is specified by the patient's physician or Authorized Healthcare Practitioner, the patient must meet the blood bank's allogeneic criteria to be drawn.
<b>Comments/Special Instructions or Precautions: (Required for all draws &lt;500mL)</b>			

## Physician or Authorized Healthcare Practitioner's Pre-Assessment of Patient: Please check for past or present medical conditions.

<input type="checkbox"/> Angina	<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> Seizures
<input type="checkbox"/> Anticoagulant Therapy (Current)	<input type="checkbox"/> CHF - Symptomatic	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Aortic/Subaortic Stenosis	<input type="checkbox"/> Recent MI (<6 months ago)	<input type="checkbox"/> Strokes/TIA
<input type="checkbox"/> Cardiomyopathy	<input type="checkbox"/> Recent Stent Placement (<6 months ago)	<input type="checkbox"/> Other:
<b>Is patient capable of transferring to donation bed independently?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Additional Comments:</b>		

## Physician or Authorized Healthcare Practitioner Information (ALL Fields Mandatory)

Physician or Authorized Healthcare Practitioner Name (Please Print)		Office Phone # ( )	Fax # ( )
Office Email Address		Address	
<i>In my opinion, there are no medical findings that would preclude this patient from completing a Therapeutic Whole Blood procedure. I understand patient eligibility is subject to the approval of the blood bank CMO or designee.</i>			
Physician or Authorized Healthcare Practitioner Signature			Date

## Blood Bank use only:

Entered into SafeTrace by (Staff ID and Date):	Verified in SafeTrace by (Staff ID and Date):
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