HEREDITARY HEMOCHROMATOSIS AND TESTOSTERONE THERAPY PHLEBOTOMY ORDER

All information MUST be filled out in its entirety to be considered valid.

Please fax completed form to (405) 297-5598 ATTENTION: Special Donation Coordinator
For Questions please call (405) 297-5597

PATIENT INFORMATION					
Patient Name:				D.O.B.	
Mailing Address:				Gender	☐ Male ☐ Female
City:		State:		Zip Code:	
Phone Number:	( )	Alternate Number:	( )		

All orders are for whole blood collection procedures; approximately 500 mL of blood will be removed from the patient with each collection. Orders are valid for 1 year.

I. Reason for draw:

☐ Hereditary Hemochromatosis ☐ Testosterone Therapy needing phlebotomy

II. Frequency (mark **ONE** of the following **DO NOT** *write in additional frequencies*.):

☐ Weekly ☐ Every 2 weeks ☐ Every 4 weeks ☐ Every 8 weeks

III. Hemoglobin:

Patients **WILL** be drawn to a minimum **Hemoglobin level of 13**.

The blood institute does **NOT** perform ferritin levels and cannot perform phlebotomy for ferritin levels.

****For Hereditary Hemochromatosis patients ONLY****

If phlebotomy is needed to lower HgB below 13 document below. HgB must be greater than or equal to 11.

Phlebotomy should **NOT** be performed if HgB is less than: _____

Ordering Health Care Provider Signature:		Date:	
Printed Ordering Health Care Provider Name:			
Office Phone:	( )	Fax:	( )

Blood Institute Personnel Only					
BECS Patient ID:		**Date order received:**		**Date Order entered in BECS:**	
Deferral Code Posted:		**Date Deferral Posted:**		**Tech ID: (Order Entry)**	
Comment Section:					
Reviewed by:		**Date Reviewed:**			