Special Services
Fax #: 480-795-2376
Email: donorcarespecialservices@vitalant.org

Therapeutic Phlebotomy Order

Notes and Instructions

- Orders are valid for a maximum of 12 months. Certain requests or changes to an existing order are subject to Vitalant MD approval.
- *Defaults:
  - The default whole blood collection volume of 500 mL will be used if field is left blank. The collection volume may be adjusted based on the patient's total blood volume.
  - Minimum Hgb allowed is 11.0 g/dl. If hgb field is left blank, default value of 12.5 g/dl females and 13.0 g/dl for males will be used.
- Donors may come in less frequently than indicated but not more frequently unless approved by a Vitalant MD.
- A therapeutic cost recovery fee may be applicable for each phlebotomy performed. Payment is due when the appointment is scheduled.
- **NOTE: Vitalant does not perform ferritin or CBC testing. No saline reinfusion is provided.**

Patient Name: _____ Sex: _____ Date of Birth: _____

Address: _____

Primary Phone: _____ Cell Phone: _____ Email Address: _____

List any medical conditions that could impact safety such as cardiac, vascular, pulmonary disease, or positive infectious diseases.

_____

Diagnosis, Hgb Threshold, Draw Volume and Frequency

Polycythemia	Polycythemia	Hemochromatosis	Porphyria Cutanea Tarda	Other
☐ Due to Testosterone Therapy	☐ Primary Vera ☐ Secondary (smoking or altitude)	☐ Hereditary **(HH) ☐ Non-Hereditary	☐ Porphyria Cutanea Tarda (PCT)	☐ Diagnosis: _____ (Vitalant FMD approval required)
Draw if Hgb is at least **15.0** g/dl	Draw if Hgb is at least _____g/dl	Draw if Hgb is at least _____g/dl	Draw if Hgb is at least _____g/dl	Draw if Hgb is at least ____g/dl
☐ *Whole Blood (500 mL) OR ☐ WB ½ unit (250 mL)	☐ *Whole Blood (500 mL) OR ☐ WB ½ unit (250 mL)	☐ *Whole Blood (500 mL) ☐ WB ½ unit (250 mL) ☐ **Double Red Cells **(HH diagnosis only)	☐ *Whole Blood (500 mL) OR ☐ WB ½ unit (250 mL)	☐ *Whole Blood (500 mL) OR ☐ WB ½ unit (250 mL)
☐ Weekly **(maximum of 4 wks in a row)** *Then maintenance collection:* ☐ Monthly ☐ Every 8 weeks ☐ Other_____	☐ Weekly **(maximum of 4 wks in a row)** *Then maintenance collection:* ☐ Monthly ☐ Every 8 weeks ☐ Other_____	☐ Weekly **(maximum of 4 wks in a row)** *Then maintenance collection:* ☐ Monthly ☐ Every 8 weeks ☐ Other_____	☐ Weekly **(maximum of 4 wks in a row)** *Then maintenance collection:* ☐ Monthly ☐ Every 8 weeks ☐ Other_____	☐ Weekly **(maximum of 4 wks in a row)** *Then maintenance collection:* ☐ Monthly ☐ Every 8 weeks ☐ Other_____

Ordering Healthcare Provider Information

NOTE: The ordering healthcare provider **must** have privileges in the state where the phlebotomy will be performed.

Name: _____ Provider State: _____ License #: _____

Address: _____

Phone Number: _____ Fax Number: _____ Person Completing form: _____

Provider Signature: _____ Date: _____

Vitalant Use Only

Date Order Received: _____ Reviewer Signature: _____

Valid through Date: _____ FMD Name (if approval is needed): _____

Protocol Information

Donor ID: _____ Therapeutic Fee: ☐ Yes ☐ No

Protocol #: _____ ☐ Therapeutic Deferral added

Patient #: _____ ☐ NA-HH/TT Donor

EC/Date:_____

Subsequent Protocol #: _____

EC/Date:_____

Subsequent Protocol #: _____

EC/Date:_____

Comments: