

Therapeutic Phlebotomy Request

Ref: 03-04-01

Special Donations Department Tel: (650) 723-6667 FAX: (650) 723-8155

PHYSICIAN ORDER FOR THERAPEUTIC PHLEBOTOMY:

Patient Name _____ Date of Birth: _____

Patient Phone: Day: _____ Eve: _____ Cell: _____

Diagnosis (Reason for therapeutic phlebotomy): _____

ICD Code _____

*** **Notes:** - All therapeutic phlebotomy orders must be written by a physician, otherwise patients will not be accepted.

All patients must have appointments for phlebotomy. No walk-ins are accepted. *Instruct patient to call 650-723-6667 to schedule an appointment.*

COLLECT approximately __475mL blood every _____ week(s) X _____ TIMES. With a minimum

Hemoglobin of _____ g/dL

Note: Orders are valid for 12 months from the date signed.

NOTE: SBC will NOT collect blood from patients with **Hgb < 11.0 g/dL (Hct < 33%)** by **finger stick evaluation at the time of presentation.**

ADDITIONAL COMMENTS: _____

Physician Name (please print): _____

Physician Signature: _____ Date: _____

Physician Phone (Required): _____ Physician Fax (Required): _____

Physician Address (Required): _____

Stanford Blood Center Use Only:

FOR BLOOD CENTER USE ONLY			
Collect Prepayment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No (list reason under exception)	\$
Exception:			
Comments:			
SD Initials:			Date:
Physician Contact Info. Verified by:			Date: