

Notes and Instructions: Form must be filled out completely.

Fax Completed Request: 563-823-8941

For questions, call: 563-823-4132

To download this form, visit <https://www.bloodcenter.org/hospitals/integrative-clinical-services/>

Notes:

- Orders are valid for a maximum of 12 months. Specific requests or changes to an existing order require a new order to be submitted.
- The collection volume is based on the patient’s total blood volume and ranges from 470-520mL. However, there are circumstances that may lead to a collection volume outside of this range.
- Minimum Hgb for phlebotomy is 11.0 g/dl.
 - ImpactLife Hgb analyzer reports a value range of 7.0-17.0 g/dL.
 - Values between 17.1-20.0 will be reported as 17.1 g/dL. Values greater than 20.0 will be reported as 20.1 g/dL
- The frequency of PRN will default to 8 weeks.
- ImpactLife does not perform ferritin or CBC testing. No saline reinfusion is provided.
- ImpactLife does not perform STAT phlebotomies. Walk-ins are not accommodated.

Documents required with every order: recent labs, current medication list, and a clinical summary (H&P).

Patient Information

Patient Name:

Date of Birth:

Gender: Male Female

Address:

Primary Phone:

Email Address:

Diagnosis

<input type="checkbox"/> Polycythemia Secondary to testosterone therapy	<input type="checkbox"/> Polycythemia Rubra vera	<input type="checkbox"/> Hereditary Hemochromatosis (HH) <input type="checkbox"/> Nonhereditary	<input type="checkbox"/> Porphyria Cutanea Tarda (PCT)	<input type="checkbox"/> Other (Please specify, provide ICD- code) _____
---	--	--	--	---

Frequency

Every _____ week(s)

One time ONLY

Other (please specify): _____

Ordering Healthcare Provider Information

Name:

Address:

Phone Number:

Fax number:

Email address:

By signing below, I acknowledge that therapeutic phlebotomy is a prescribed procedure performed to manage medical conditions requiring controlled blood removal and is associated with risks including but not limited to vasovagal reactions, hypotension, hematoma, and nerve injury. I confirm the patient is medically stable and that benefits of therapeutic phlebotomy outweigh the risks.

Providers signature: _____ **Date:** _____



**FORM P-176: REQUEST FOR THERAPEUTIC
PHLEBOTOMY**

For ImpactLife Use only		
Received date: _____	Patient is: <input type="checkbox"/> New <input type="checkbox"/> Returning	Order #: _____
Patient name and DOB verified: <input type="checkbox"/>	Donor ID#: _____	
Eligible to screen for	<input type="checkbox"/> Testosterone whole blood	
	<input type="checkbox"/> Hemochromatosis	
	<input type="checkbox"/> Not eligible/ therapeutic	
Deferral code, if added: _____ <input type="checkbox"/> N/A		
Patient Notified <input type="checkbox"/> Date: _____ Method: <input type="checkbox"/> Text <input type="checkbox"/> email <input type="checkbox"/> phone/voicemail		
Ordering Provider notified (if order denied): Yes <input type="checkbox"/> N/A <input type="checkbox"/>		
Staff completing order: _____ Date: _____		
Notes: _____ _____ _____ _____ _____ _____ _____		