

Notes and Instructions: Form must be filled out completely.

Fax Completed Request: 563-823-8941

For questions, call: 563-823-4132 or email integrativeclinicalservices@impactlife.org

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

☐ **Polycythemia**
Secondary to
testosterone therapy

☐ **Polycythemia**
Rubra vera

☐ **Hereditary**
Hemochromatosis
(HH)
☐ Nonhereditary

☐ **Porphyria**
Cutanea Tarda
(PCT)

☐ 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**

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