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Puget Sound Blood Center — research | medicine | blood & tissue services

Therapeutic Phlebotomy Order Form
Special Collections

1021 112th Ave NE Bellevue, WA 98004
(800) 266-4033 or (425) 453-5098 Fax (425) 462-4316

Date: ________________ ***This order is valid for one year***

Patient's Legal Name__________________________ ______________________________ ______________________
Last **First** **Middle Name or Initial**

❑ Male ❑ Female Patient's Birthdate ___/____/_____ Best Contact Phone # (____)____________❑ cell ❑ work ❑ home

Patient's Address ____________________________________ ___________________ __________ ___________
Street City State Zip Code

Diagnosis which is requiring patient's blood to be drawn:
❑ Hereditary Hemochromatosis (proven or suspected) ❑ Other (specify diagnosis)______________________

Amount:

❑ One unit (500 mL) ***Amount will be proportionally reduced if patient weighs less than 110 lbs***

❑ Less than one unit *(specify amount)*: ___________

Frequency:

❑ One time only ❑ Weekly ❑ Monthly ❑ Every ____weeks ❑ Every ___months

❑ ___ times only for ___months *(ex: _3_ times only for 3 months)* ❑___ times only *(ex: _6_times only)*

Default minimum hemoglobin is 10.9 g/dL. If a *higher* minimum hemoglobin is desired please specify: _____g/dL

Please identify if your patient has any of the following conditions: (If your patient has one of these conditions, he/she may not be drawn. Please contact our office for questions or information)

❑ Angina ❑ Aortic Stenosis ❑ Congestive Heart Failure ❑ Heart Valve Disease ❑ Mitral Valve Prolapse
❑ Myocardial Infarction (MI) ❑ Shortness of Breath ❑ Subaortic Stenosis ❑ Unstable Angina

Please identify if there are any Special Instructions or Precautions:

____

______________________________ ______________________________
Physician Signature Physician Name *(Please Print)*

______________________________ ________________ ________________
Physician Address Phone FAX