Bloodworks

Time Square, 660 SW 39th Street, Suite 245, Renton, WA 98057
(800) 266-4033 or (425) 453-5098 Fax (206) 251-1977
Email: therapeuticphlebotomy@bloodworksnw.org

Patient Medical Condition Evaluation by Personal Health Care Provider

(Only complete when a condition is present)

Patient's Legal Name (First, Middle, Last**)** _____, _____, _____

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

The conditions below, depending on severity, can be associated with increased risk for symptoms resulting from blood loss though blood donation (approximately 10% blood volume loss). Please check *all* that apply.

❑ Angina (❑Stable ❑Unstable) ❑ Myocardial Infarction (Dates _____)

❑ Congestive Heart Failure ❑ Hypertrophic Cardiomyopathy/Subaortic Stenosis ❑ Restrictive Cardiomyopathy

❑ Heart Valve Disease: Risk for endocarditis? ❑ Yes ❑ No

❑ Dysrhythmia ❑ Other_____

Symptoms/Signs

❑ Asymptomatic ❑ Chest pain ❑ Shortness of breath ❑ Abnormal heart rate/rhythm

❑ Other_____

Typical frequency _____ times per ❑ Day ❑ Week ❑ Month ❑ Year ❑ Other _____

Typical duration: _____ to _____ ❑ Seconds ❑ Minutes ❑ Hours ❑ Days ❑ Other _____

Activity limitations: ❑ None ***Patient must be able to transfer to the donor bed with minimal assistance*

❑ Able to walk _____ ❑ feet, ❑ blocks, ❑ miles on level ground

❑ Able to climb _____ flights of stairs ❑ Symptoms at rest

To the best of my knowledge:

This patient ❑is ❑is not likely to be adversely affected by the loss of approximately 10% of their blood volume.

Physician Signature	Date	Physician Name *(Please Print)*

Physician Address	Phone	FAX

Bloodworks Physician Signature:_____ Date: _____

Draw to be performed at Central Seattle Donor Center only: ❑ Yes ❑ No