

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

Patient Medical Condition Evaluation by Personal Health Care Provider

(Only complete when a condition is present)

ent's Legal Name (Firs 1ale ☐ Female Patien						
The conditions below blood loss though bl Angina (Stable Congestive Heart Heart Valve Disease Dysrhythmia	lood donation (ap Dunstable) = t Failure = Hyp	proximately 10 Myocardial Incertrophic Carditis?	0% blood volu farction (Date diomyopathy/	me loss). Please	check <u>all</u> that apply	/.)
Symptoms/Signs Asymptomatic Other	•	☐ Shortnes			heart rate/rhythm	
Typical frequency Typical duration: Activity limitations: □ Able to walk Able to climb	to □ □ None **Patien □ feet, □ blo	Seconds \(\sigma \) Not must be able ocks, \(\sigma \) miles	dinutes ☐ Ho to transfer to on level grou	urs Days Dot the donor bed wit	ther	ce
To the best of my known This patient ☐ is volume.	-	y to be adverse	ly affected by	the loss of approx	ximately 10% of the	ir blood
Physician Signa	ture	Date		Phy	ysician Name (<i>Please</i>	e Print)
Pł	hysician Address			Phone		FAX
Bloodworks Physician Signature:				Date:		