Therapeutic Whole Blood Phlebotomy Request

General Information

- Patients **MUST** have an appointment
- Patients **MUST** have a written order prior to scheduling an appointment
- Call the Special Procedures Scheduling appointment line: **1-877-659-2001**
- Fax request to: **619-297-4064**
- Therapeutic orders are valid for 1 year unless otherwise specified
- Volume to be collected 500mL or 250mL
- Patient must have completed any antibiotic therapy prior to therapeutic appointment.
- Only medically stable patients will be drawn. Medically unstable patients, including patients with severe shortness of breath or severe heart conditions, cannot be drawn.

Patient Information (ALL Fields Mandatory)

Last Name	First (Legal) Name	Middle Initial	Suffix	Gender ☐ M ☐ F	Birth Date (mm-dd-yy)

Parent/Guardian Name (If patient is a minor)	Address	City	State	Zip

Primary Language	Weight	Phone Number ( ) ☐Home ☐Cell ☐Work
		Alternate Phone Number ( ) ☐Home ☐Cell ☐Work

Diagnosis
☐ Hereditary Hemochromatosis ☐ High Hgb secondary to TRT ☐ Other:_____

Phlebotomy Information (ALL Fields Mandatory)

Frequency	Requested Volume (Required)	Target Hgb or HCT at or below which blood will not be drawn
☐ Weekly ☐ Monthly ☐ Bi-Weekly ☐ Other: (See Comments)	☐ 250mL ☐ 500mL	**Note**: Target Hgb of <12 g/dL must be cleared by SDBB CMO prior to appointment. If target Hgb/HCT not specified, Therapeutic Patient must meet allogeneic criteria to be drawn. **Target Hgb or HCT:**

Comments / Special instructions or Precautions: (Required for all draws <500mL)

Physician's Pre-Assessment of Patient: *Please check for past or present medical conditions.*

☐ Angina	☐ Cardiovascular Disease	☐ Seizures
☐ Anticoagulant Therapy (Current)	☐ CHF- Symptomatic	☐ Shortness of Breath
☐ Aortic / Subaortic Stenosis	☐ Recent MI (<6 months ago)	☐ Strokes/TIA
☐ Cardiomyopathy	☐ Recent Stent placement (<6 months ago)	☐ Other:

Is patient capable of transferring to donation bed independently? ☐ Yes ☐ No

Additional Comments:

Physician Information (ALL Fields Mandatory)

Physician Name (Please Print)	Office Phone Number ( )	Fax Number ( )

Office Email Address	Address

In my opinion, there are no medical findings that would preclude this patient from completing a Therapeutic WB procedure. I understand that the patient eligibility is subject to SDBB CMO approval.

Physician Signature **Date**

Blood Bank use only:

Entered into Safe Trace by (*Staff ID and Date*):	Verified in Safe Trace by (*Staff ID and Date*):