University Health

*Effective: January 2025*

# Therapeutic Phlebotomy Order

**Please fax completed form to UH Blood Donor Services**: Fax Number- 210-358-4616; Phone Number- 210-358-2812

**PATIENT INFORMATION**

Name _____ Sex_____ Date of Birth _____
Address _____
Home Phone _____ Alternate Phone _____

**Diagnosis**

☐ Secondary Erythrocytosis due to Testosterone Replacement Therapy

☐ Primary Polycythemia ☐ Secondary Polycythemia due to: _____

☐ Hereditary Hemochromatosis ☐ Non-Hereditary Hemochromatosis ☐ Porphyria Cutanea Tarda

☐ Other, specify: _____

**Note: Other conditions may require additional information and UH MD / Designee approval.**

List any medical conditions that we should be made aware of:

**TYPE OF PHLEBOTOMY**

☐ Whole Blood **(500 mL )** * ☐ Whole Blood ½ unit (250 mL) **** Standard phlebotomy***

**FREQUENCY AND DURATION OF PHLEBOTOMY**

☐ One time only ☐ Weekly ☐ Every _____ weeks ☐ Every _____ months

**Additional Instruction, if indicated:**

Total number of Procedures _____

Number of months Therapeutic Phlebotomy prescription is valid: _____ (Maximum 12 months)

**MINIMUM HEMOGLOBIN**

Do not permit phlebotomy if hemoglobin is below _____ . UH minimum is 11.0 for whole blood

- Therapeutic phlebotomy fees are applicable for therapeutic collections.
- UH does not perform ferritin/CBC testing. No saline reinfusion is provided

**ORDERING PHYSICIAN INFORMATION**

Physician signature_____ Physician name _____ Date _____
Office address _____
Office phone number _____ Fax number _____

**UH USE ONLY**

Order Valid Through Date: (1 year from Ordering Physician date) _____

UH Transfusion Medicine Physician request approval:

"The patient's medical history, current vital signs, hemoglobin and physician's order was reviewed and there is no contraindication for therapeutic phlebotomy. The patient may be phlebotomized as detailed above."

UH MD / Designee signature _____ Date_____