



Therapeutic Special Collection Request

Patient Name: (Last, First, Middle, Suffix)*					
*The patient's name must appear <u>exactly</u> as it appears on the picture ID which will be presented at the time of donation					
Address:	Street	Apt.	City	State	Zipcode
Phone:	Home:	Business:	Cellular:		
Age:	DOB:	Gender:	Weight:		

Medical Condition Requiring Therapeutic Phlebotomy: _____

Physician Information

Requesting Physician: _____ Office Phone: _____ Fax: _____
 Contact Person: _____ Address: _____

Phlebotomy Order

Amount of Blood to be drawn:	1 unit of Whole Blood
Acceptable Hgb level at which the patient should be drawn:	_____
Phlebotomy Frequency (e.g., every 8 weeks):	_____

****This order is valid for 1 year from order date****

Ordering Physician's Signature: _____ **Order Date:** _____

Blood Bank of Hawaii Medical Director Review

Approved <input type="checkbox"/>	Declined <input type="checkbox"/>	Comments: _____ _____ _____
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Signature: _____ **Date:** _____