Blood Bank of Hawaii

Pt. ID#:	DID#:	Req ID#:
BBH USE ONLY		

Therapeutic Special Collection Request

Patient Name: (Last, First, Middle, Suffix)*					
*The patient's name must appear exactly 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 Review

Signature: _____ **Date:** _____