



Blood Bank of Hawaii

Therapeutic Phlebotomy Request

PATIENT INFORMATION: (Patient's legal name as it appears on a valid picture ID)

Full Name: _____ Gender: _____ DOB: _____
Last Name First Name Middle Name

Address: _____
Street Unit No. City State ZIP Code

Phone: (_____) _____ Phone: (_____) _____ Email: _____
Area Code Phone Number Area Code Phone Number

PHYSICIAN INFORMATION:

Requesting Physician: _____ Contact Person: _____

Address: _____
Street Unit No. City State ZIP Code

Phone: (_____) _____ Fax: (_____) _____ Email: _____
Area Code Phone Number Area Code Phone Number

THERAPEUTIC PHLEBOTOMY ORDER:

One unit of whole blood to be drawn at each donation. Donations can be as frequent as every 2 weeks. Patient self-schedules blood draws at the frequency directed by their physician. Approved request is valid for one year from the order date.

Diagnosis: (ICD-10 Codes are not acceptable.)

☐ Polycythemia due to TRT ☐ Hereditary Hemochromatosis

☐ Polycythemia Vera (DX date: _____)

☐ Polycythemia secondary to medical treatment other than TRT

☐ OTHER: _____

Do not draw if Hgb is less than:

_____g/dl

Requesting Physician's Signature: _____ Order Date: _____

Blood Bank of Hawaii Review

REQ ID#: _____ Patient ID#: _____ DID: _____ Staff ID: _____ Date: _____

BBH Medical Director Approval: ☐ Yes ☐ No Reason Denied: _____

BBH Medical Director Signature: _____ Date: _____