Therapeutic Phlebotomy Request

Ref: 03-04-01

Special Donations Department Tel: (650) 723-6667 FAX: (650) 723-8155

PHYSICIAN ORDER FOR THERAPEUTIC PHLEBOTOMY:

Patient Name: _____ **Date of Birth:** _____

Patient Phone: Day: _____ **Eve:** _____ **Cell:** _____

Diagnosis (Reason for therapeutic phlebotomy): _____

ICD Code: _____

- All therapeutic phlebotomy orders must be written by a physician, otherwise patients will not be accepted.
- **Orders are valid for 12 months from the date signed**
- All patients must have appointments for phlebotomy. No walk-ins are accepted. *Instruct patient to call 650-723-6667 to schedule an appointment.*

COLLECT approximately 475 mL blood following the frequency and hemoglobin requirements below. If a volume other than 475 ml is requested, please indicate volume in the ADDITIONAL COMMENTS section.

Frequency: ☐ One time only ☐ Every _____ weeks ☐ Other, specify: _____

Total number of procedures, if applicable: _____

Minimum Hemoglobin: Do not permit phlebotomy if hemoglobin is below _____g/dL.
NOTE: Stanford Blood Center will NOT collect blood from patients with a Hgb < 11.0 g/dL by fingerstick evaluation on the day of collection.

ADDITIONAL COMMENTS: _____

_____

Physician Name (please print): _____

Physician Signature: _____ **Date:** _____

Physician Phone (Required): _____ **Physician Fax (Required):** _____

Physician Address (Required): _____

Stanford Blood Center Use Only:

FOR BLOOD CENTER USE ONLY		
Collect Prepayment?	**❒Yes**	**❒No (list reason under exception)** **$**
Exception:		
Comments:		
SD Initials:		Date:
Physician Contact Info. Verified by:		Date: