San Diego Blood Bank

Therapeutic Whole Blood Phlebotomy Request

General Information

- Patients **MUST** have an appointment.
- Patients **MUST** have a written order prior to scheduling an appointment.
- Call the Special Procedures Scheduling appointment line: **(877) 659-2001**.
- Fax request to: **(619) 297- 4064**.
- Therapeutic orders are valid for 1 year unless otherwise specified.
- Volume to be collected - 500mL or 250mL
- Patient must have completed any antibiotic therapy prior to therapeutic appointment.
- Only medically stable patients will be drawn. Medically unstable patients, including patients with severe shortness of breath or severe heart conditions, cannot be drawn.

Patient Information (ALL Fields Mandatory)

Last Name	First (Legal) Name	Middle Initial	Suffix	Gender ☐ M ☐ F	Birthdate (mm-dd-yyyy)

Name of Parent/Legally Authorized Representative State Relationship:	Address	City	State	Zip

Primary Language	Weight	Mobile Phone # ( )	
		Alternate Phone # ( )	☐Home ☐Work ☐Other

Diagnosis/Condition ***(Mark all that apply)***
☐ Hereditary Hemochromatosis ☐ Polycythemia Vera ☐ Erythrocythemia ☐ Taking Testosterone ☐ Other:_____

Phlebotomy Information (ALL Fields Mandatory)

Frequency	Requested Volume (Required)	Target hct at or below which blood will not be drawn
☐ Weekly ☐ Monthly ☐ Biweekly ☐ Other: (See Comments)	☐ 250mL ☐ 500mL	**Target hct:** _____ **Note**: Target hct of < 33% must be cleared by the blood bank CMO or designee prior to appointment. If no target hct is specified by the patient's physician or Authorized Healthcare Practitioner, the patient must meet the blood bank's allogeneic criteria to be drawn.

Comments/Special Instructions or Precautions: (Required for all draws <500mL)

Physician or Authorized Healthcare Practitioner's Pre-Assessment of Patient: *Please check for past or present medical conditions.*

☐ Angina	☐ Cardiovascular Disease	☐ Seizures
☐ Anticoagulant Therapy (Current)	☐ CHF - Symptomatic	☐ Shortness of Breath
☐ Aortic/Subaortic Stenosis	☐ Recent MI (<6 months ago)	☐ Strokes/TIA
☐ Cardiomyopathy	☐ Recent Stent Placement (<6 months ago)	☐ Other:

Is patient capable of transferring to donation bed independently? ☐ Yes ☐ No

Additional Comments:

Physician or Authorized Healthcare Practitioner Information (ALL Fields Mandatory)

Physician or Authorized Healthcare Practitioner Name (Please Print)	Office Phone # ( )	Fax # ( )

Office Email Address	Address

In my opinion, there are no medical findings that would preclude this patient from completing a Therapeutic Whole Blood procedure. I understand patient eligibility is subject to the approval of the blood bank CMO or designee.

Physician or Authorized Healthcare Practitioner Signature **Date**

Blood Bank use only:

Entered into SafeTrace by (*Staff ID and Date*):	Verified in SafeTrace by (*Staff ID and Date*):