Reference: C.02.002 Therapeutic Donation

Patient's Full Name: ____ Gender: _____ DOB: ___________
Last First Middle

Patient's Mailing Address:______________________________ City/ State/ Zip: ________________________

Primary Phone # (______)______________________ Secondary Phone #(______)_____________________

Diagnosis: *No ICD codes accepted*

- ☐ Polycythemia due to testosterone therapy (TRT) but does not qualify for crossover **NO FEE**
- ☐ Hereditary Hemochromatosis but does not qualify for crossover **NO FEE**
- ☐ Polycythemia Vera (Diagnosis Date:_______________)
- ☐ Polycythemia secondary to medical treatment other than TRT
- ☐ Other: ____

Disclaimer:
We Are Blood (WrB) does NOT perform ferritin levels and cannot perform phlebotomy for a specific ferritin value. Please be aware your patient will be assessed a fee for therapeutic phlebotomy, except as specified above.

Patients will be drawn at a minimum Hgb of 13.0g/dL for biologically born males and non-specified gender, and 12.5g/dL for biologically born females.

☐ **If target Hgb is less than specified above, document the target Hgb:** ________________________________

Draw one (1) unit of whole blood (approximately 500mls)

☐ One (1) time only ☐ Weekly ☐ Monthly ☐ Every two (2) months
☐ Every three (3) months ☐ Every six (6) months ☐ Other: ________________________________

CALL (512) 206-1265 FOR APPOINTMENTS

I certify that this patient's physical condition is such that the phlebotomies should not affect them adversely. I further certify that the above-named patient was examined by me, diagnosed, and the phlebotomy requested.

I understand that WrB will perform a hemoglobin, temperature, pulse, and blood pressure prior to the phlebotomy and that no other tests are performed on the patient or the patient's blood.

I understand that this order will automatically expire 1 year from date of physician signature or upon receipt of new orders.

PHYSICIAN'S NAME: ____

PHYSICIAN'S SIGNATURE ____ **DATE:** ______________

Phone# (______)__________________________ **Fax# (______)**__________________________

Fax or email completed order form to 512-206-1365 or WrBClinicalServices@weareblood.org

For WrB Clinical Services Use ONLY

DID:________________ Previous THER? ☐ Yes ☐ No Deferral posted by/date:__________

Existing Deferral for any reason other than TT? ☐ Yes ☐ No Medical Clearance required? ☐ Yes ☐ No

Completed by/date:______________________ CS Management Review: __________________

Reference: C.02.002 Therapeutic Donation

A. Revision History

Revision No.	Effective Date	Section	Description	DCC No.
.01	N/A	N/A	New form	N/A
.02	11-20-2002	N/A	Removed “Desired HCT:” and added “Please Note: We will not draw the donor if their HCT is at or below this value or if this space is left blank.	N/A
.03	03-21-2006	All	Converted document to new template; Added Physician’s fax number. Removed “Pertinent Information from Physical Examination” and added Comments. Added date format for “Begin Therapy”	05-062
.04	09-03-2013		Updated as a result of annual review. Diagnosis; added note about ICD9 codes, added field for diagnosis date. Removed Patient Data fields. Reformatted in accordance with QP.01.001.	13-009
.05	01-27-16		Updated form template for document improvement. Updated expiration date of physician’s request from 6 months to one year of physician’s signature. Removed the “BEGIN THERAPY” date.	15-133
.06	07-25-18		Rebranding. Added contact information to form.	17-089
.07	10-01-19		Update to include HGB	19-084
.08	06-17-20		Update for TTCX and removed erythrocytosis	19-168
.09	04-20-22		Added DID and deferral evaluation and documentation section.	22-004
.10			CR-21-0027 BBCS Upgrade. Clarified Hgb requirements for expanded gender options. Added a review section at bottom.	22-073