

Reference: C.02.002 Therapeutic Donation and C.02.028 Therapeutic Crossover

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

Patient's Mailing Address: _____ City/ State/ Zip: _____

Primary Phone # (_____) _____ Secondary Phone # (_____) _____

DIAGNOSIS: Polycythemia secondary to Testosterone Replacement Therapy (TRT) ONLY

- **Patients will be drawn to a minimum Hgb of 13g/dL for biologically born males or non-specified gender and Hgb of 12.5g/dL for biologically born females.**

Disclaimer: We Are Blood (WrB) does NOT perform ferritin levels and cannot perform phlebotomy for a specific ferritin value.

- **Draw 1 unit of whole blood (approximately 500mls)**

Choose from boxes available.

Every 2 months this frequency is highly recommended and will offer the most scheduling choices for the patient

Additional frequency options: Every 4 weeks Every 2 weeks

Patients meeting donor criteria may volunteer to donate their blood for the community as long as all donation criteria, including Hgb, is met at the time of donation. Patients who do not meet all donation criteria will be drawn as a therapeutic donation and their unit will be discarded and no additional tests will be performed on the patient or the patient's blood. **NO FEE** will be charged for this phlebotomy for a diagnosis of Polycythemia Secondary to TRT.

CALL (512) 206-1265 FOR APPOINTMENTS OR QUESTIONS

Physician Certification: I certify that this patient is under my care and has been diagnosed with **polycythemia secondary to testosterone therapy**. To my knowledge, the patient does not have any other bleeding disorders/ blood diseases or blood conditions. The patient's physical condition is such that the phlebotomies should not affect them adversely.

I understand that this order will automatically expire 1 year from date of physician signature or upon receipt of updated orders. Contact We Are Blood for alternate orders if patient does not meet all stated criteria.

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- TTCX Enrollment

DID: _____ Existing TTCX comment? Yes No Previous THER? Yes No

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

Qualification: TTCX THER (Deferral posted by/date: _____) Re-entry Date: _____ N/A

TTCX Comment posted by/date: _____ N/A CS Management Review: _____

A. Revision History

Revision No.	Effective Date	Description	DCC No.
.01	06-17-20	New form	19-168
.02	04-20-22	Updated header reference. Removed “additional comments will void the form”. Added section to WrB CS use only section to document deferral posting, if applicable.	22-004
.03		CR-21-0027 BBCS Upgrade. Clarified Hgb requirements based on gender options.	22-073