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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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 |