|  |
| --- |
| Patient’s Full Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_ |
|  Last First Middle |
|  |
| Patient’s Mailing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/ State/ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| Primary Phone # (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Phone #(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

|  |
| --- |
| **Patients will be drawn to a minimum Hgb of 13g/dL for biologically born males and non-specified gender and Hgb of 12.5g/dL for biologically born females.** |
| **[ ]  If target Hgb is less than indicated above, document the target Hgb below:** |
|  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  |
| **Disclaimer:** |
| **We Are Blood (WrB) does NOT perform ferritin levels and cannot perform phlebotomy for a specific ferritin value. Please be aware that NO FEE will be assessed for patients with a diagnosis of Hereditary Hemochromatosis.** |
|  |
| **Draw 1 unit of whole blood (approximately 500mls)** |
| [ ]  Every 2 months [ ]  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. |

 **CALL (512) 206-1265 FOR APPOINTMENTS**

**I certify that this patient is under my care and has been diagnosed with Hereditary Hemochromatosis. To my knowledge, the patient does not have any other bleeding disorders/ blood diseases or blood conditions, including blood conditions that occur secondary to prescribed medications/ treatments (i.e., erythrocytosis or polycythemia). The patient’s physical condition is such that the phlebotomies should not affect them adversely.**

**Note:** If a specific hgb is desired or if the frequency of phlebotomies exceeds what the FDA allows, a yearly order must be on file for the patient. We will request new orders when the current order expires (one year from signature date).

**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- HHCX Enrollment

DID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Existing HHCX comment? [ ]  Yes [ ]  No Previous THER? [ ]  Yes [ ]  No

Existing Deferral for any reason other than HH? [ ]  Yes [ ]  No Medical Clearance required?[ ]  Yes [ ]  No

Qualification: [ ]  HHCX [ ]  THER (Deferral posted by/date:\_\_\_\_\_\_\_\_\_\_) Re-entry Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  N/A

HHCX Comment posted by/date: \_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  N/A CS Management Review:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Revision History

| **Revision No.** | **Effective Date** | **Description** | **DCC No.** |
| --- | --- | --- | --- |
| .01 | 04-30-19 | New form | 19-028 |
| .02 | 10-01-19 | Update to include HGB values | 19-084 |
| .03 | 04-20-22 | Updated HGB target values and add Clinical Services documentation of deferral posting, if applicable. | 22-004 |
| .04 | 11-17-22 | Clarified hgb requirements for expanded gender options | 22-073 |
| .05 |  | Removed line regarding orders expire 1 yr from date of signature & added clarifying verbiage for orders. | 23-094 |