

**PHYSICIAN'S AUTHORIZATION FOR THERAPEUTIC PHLEBOTOMY**

**Directions: Physician or designee, please complete ALL sections of this authorization and Fax to: 816-968-4416**

Questions: Contact the Special Donations Office at 816-968-4081 or toll free 1-888-647-4040 x1081

<b>SECTION 1: Patient Information</b>	
Patient Name:	Date of Birth:
Diagnosis: <input type="checkbox"/> Hereditary Hemochromatosis <input type="checkbox"/> Secondary Hemochromatosis <input type="checkbox"/> Other _____	Home Phone #: (    ) Work Phone #: (    )
Does the patient have a diagnosis that puts him/her at risk in the event of a phlebotomy complication (e.g. vasovagal response, hypotension, etc.)	<b>Circle One:</b> Yes No
If yes, please explain:	

<b>SECTION 2: Phlebotomy Instructions</b>	
Phlebotomy should <b>not</b> be performed <b>if hemoglobin is less than</b> (please specify)	g/dL
<b>Frequency</b> of Therapeutic Phlebotomy procedure (please specify)	
If the amount of blood drawn <b>should not</b> be in the <b>500 mL ± 50 mL range</b> , specify the amount that should be drawn:	
Volume to draw:	

<b>SECTION 3: Authorization Period</b>
<b>This authorization is valid for one year.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
Please specify time limits if these instructions are for <b>less</b> than one year.

<b>SECTION 4: Physician Information</b>	
Physician's Name (please print):	Physician's Phone #: (    ) Physician's Fax #: (    )
Physician's Signature:	Date: