

Request for Therapeutic Phlebotomy

FAX REQUEST TO: (832) 930-4888. For questions, call (713) 791-6608.

Incomplete forms are not accepted. Request is valid for one (1) year.

- HH and TRT patients being drawn ≥ 8 weeks apart *DO NOT* need a prescription if they meet allogeneic eligibility.
- It is the responsibility of the patient to call **(713) 791-6608** and verify their order has been processed before scheduling an appointment or presenting at location to be drawn.
- No CBC or ferritin testing provided.
- GCB will only draw standard whole blood units of 500 mL, +/-50mL.

Full Legal Name (as it appears on ID)

First: _____ Middle Initial: _____ Last: _____

Full Mailing Address

Street: _____ Date of Birth: _____
 Telephone #: _____
 City: _____ State: _____ Zip: _____ SSN (Last 4 digits only): XXX-XX-

Diagnosis - Reason for Phlebotomy

☐ **Testosterone Replacement Therapy** with Secondary Polycythemia (TRT) D75.1 ☐ **Hereditary Hemochromatosis (HH)** E83.110

☐ **Other** – ICD-10 Code: _____ Diagnosis: _____ (both are required)

Minimum Hematocrit for Phlebotomy

Do not perform phlebotomy if hematocrit is below ____%.
GCB will not draw a minimum HCT below 33%

Frequency

Required: ☐ One time ONLY Or ☐ Every _____ week(s)

Optional: ☐ Hold collections after _____ # of collections - Request will expire once filled.

Known Communicable Disease (HIV, HCV, HBV, etc.): YES ☐ NO ☐

Ordering Provider Information and Acknowledgement

By signing below, **the treating provider confirms** they are authorized to practice in Texas, and the patient will be able to tolerate therapeutic phlebotomy procedure(s). Furthermore, the patient does not have any medical contraindications for blood draws. The risks and benefits of therapeutic phlebotomies have been discussed with the patient.

Medical Doctor (required) Printed Name: _____	NP/PA (if applicable) Printed Name: _____
Signature of MD or NP/PA: _____	Date: _____

Full Mailing Address Street: _____	Telephone: _____ Fax: _____
City: _____ State: _____ Zip: _____	E-mail: _____

GCB Medical Services USE ONLY

e-Delphyn ID: _____	Completed by/Date: _____
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