



Innovative Blood Resources
 737 Pelham Boulevard
 Saint Paul, MN 55114
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Physicians Order Form for Therapeutic Phlebotomy

PLEASE PROVIDE ALL REQUESTED INFORMATION (PLEASE PRINT)

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Gender: _____
 Address: _____ Phone #: _____

Ordering Health Care Provider:

Name (print): _____ Telephone: _____ Fax: _____
 Address: _____
 Office contact name(s) for questions or clarifications: _____

Indications for therapeutic phlebotomy:

- DIAGNOSIS OF HEREDITARY HEMOCHROMATOSIS**
 Phlebotomy will not be performed if hemoglobin is less than 11.0 g/dL
 - Documentation of a genetic test to confirm the diagnosis of Hereditary Hemochromatosis**
 A copy of the genetic test must be attached in order to process the request for new therapeutic donors
 - Confirmation that patient is not currently taking anticoagulants or blood thinners like warfarin, heparin or other NOAC medications**
- 1 unit (approx. 500 ML) shall be drawn every: 1 week 2 weeks 4 weeks 8 weeks Other _____

Ordering Provider's Signature

Date

REMINDER:

- It is the responsibility of the ordering physician to monitor the patient to determine appropriate frequency of phlebotomy.
- Minimum donation interval is every 7 days.
- Donor must meet IBR requirements for blood pressure and pulse which will be performed on site before phlebotomy.
- Order expires every 12 months.
- Individuals with hereditary hemochromatosis may be considered for allogeneic donation if eligible by all other allogeneic donor criteria (except frequency of donation).

Information below for Innovative Blood Resources use only

Donor ID Number _____ **Order Expiration Date**

HEMODONOR Special Instruction added or verified in EDD Donor Record.

Comments: _____

Order Form Reviewed/Approved by

Date

IBR Physician - Please sign and date order form once reviewed and approved

IBR Physician's Signature

Date