Innovative Blood Resources
737 Pelham Boulevard
Saint Paul, MN 55114
Phone: 651-332-7321
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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 (~ 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 ☐ Returning Patient

Comments: _____

_____ _____
Order Form Reviewed/Approved by **Date**

IBR Physician Approval for New Patient

_____ _____
IBR Physician's Signature **Date**