

INLAND NORTHWEST BLOOD CENTER

Regional Headquarters
 210 W Cataldo Ave
 Spokane, WA 99201
 (509) 624-0151 / (800) 423-0151
 Fax: (509) 232-4526

North Idaho Center
 1341 Northwood Center Ct
 Coeur d'Alene, ID 83814
 (208) 667-5461
 Fax: (208) 292-6103

Lewis-Clark Valley Center
 1213 21st Street
 Lewiston, ID 83501
 (208) 717-0625
 Fax: (208) 717-0630

PHYSICIAN'S REQUEST FOR THERAPEUTIC PHLEBOTOMY

1. PATIENT INFORMATION

NAME: _____ DOB: _____
 ADDRESS: _____
 CITY, STATE, ZIP: _____
 HOME PHONE #: _____ WORK PHONE #: _____

2. DIAGNOSIS

Hereditary Hemochromatosis _____ Polycythemia _____
ICD9 Code
 Porphyria Cutanea Tarda _____ Other _____
ICD9 Code ICD9 Code

3. TYPE OF DONATION (Mark one or more boxes)

Double Red Cells* Whole Blood (500mLs) Whole Blood ½ unit (250mLs)
**If donor qualifies and INBC schedule permits; otherwise whole blood unit will be drawn.*

4. FREQUENCY OF PHLEBOTOMY:

Weekly Every _____ week(s) Monthly Other _____
(maximum frequency: once per week) (Please Explain)

5. MINIMUM HEMOGLOBIN to permit phlebotomy _____ *(INBC Minimum is 11.0)*

INBC Staff : _____ / _____
Initial Date

NOTE:

1. INBC does not charge fees for donors diagnosed with Hereditary Hemochromatosis
2. INBC does not perform ferritin testing.

PHYSICIAN AUTHORIZATION

 Physician Signature *(INBC will NOT accept a STAMPED signature)*

 Printed Name of Physician

 Address

 City, State, Zip

 Date

 Phone Number

 Fax Number

 NPI Number