Carter BloodCare

# ENROLLMENT/PRESCRIPTION FOR NO-FEE PHLEBOTOMY FOR HEREDITARY HEMOCHROMATOSIS (HH) PATIENTS ONLY

Please allow 3-5 business days for processing

Contact Us: FAX: (817) 412-5609 Email: DN@carterbloodcare.org Phone: (817) 412-5603

**Patient Information** (Please use patient's legal name and complete address.):

Full Name: _____ Sex: _____ DOB: _____
Last First

Address: _____ Phone #: (_____)_____
Area Code

_____ Email Address: _____
City State Zip

**Draw 1 unit of whole blood** (Approximately 500 mL)

Choose only from the available boxes below. Additional comments will void the form and it will be returned.

☐ every 8 weeks ☐ every 4 weeks ☐ every 2 weeks

NOTES:

- Patient will be drawn as long as Hgb is 13 g/dL or higher.
- If Hgb target is less than 13 g/dL, document whole value: _____ .
- Patient will not be drawn if Hgb is < 10 g/dL.

Carter BloodCare does NOT perform ferritin levels.

**Physician information:**

My signature on this form verifies that this patient is under my care and has been diagnosed with Hereditary Hemochromatosis.

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____

Phone #: (_____)_____ FAX #: (_____)_____
Area Code Phone Number Area Code Fax Number

**FOR CBC USE ONLY – Cardiac/Medical Clearance**

Donor ID#: DN_____ Cardiac Clearance Release Received Date: _____

Employee Initials: _____ Date: _____

Comments:

_____

Carter BloodCare Medical Director Approval for Phlebotomy: ☐ Yes ☐ No

CBC Medical Director Signature: _____ Date: _____


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