Carter BloodCare

ENROLLMENT/PRESCRIPTION FOR PHLEBOTOMY DUE TO TESTOSTERONE REPLACEMENT THERAPY (TRT)

Please allow 3 – 5 business days for processing

Donor Notification Dept.: Phone: (817) 412-5603 for questions Fax: (817) 412-5609 Email: DN@carterbloodcare.org

This form is only required for patients needing to be drawn more frequently than every 8 weeks OR if the patient is unable/declines to donate for the community blood supply.

Patient Information (Legibly print patient's legal name as it appears on their driver's license), fill in all blanks:

Full Name: _____ _____ _____ Gender: _____ DOB: _____
Last Name First Name Middle Name

Address: _____
Street City State Zip

Phone #: (_____)_____ Email: _____
Area Code Phone Number

Testosterone Therapy Needing Phlebotomy

- One unit of whole blood to be drawn at each donation as frequently as every 2 weeks.
- Patient self-schedules blood draws at the frequency directed by their Physician.
- Males and Non-Specified individuals are drawn with Hemoglobin ≥ 13 g/dL. Females are drawn with Hemoglobin ≥ 12.5 g/dL. All aspects of the mini-physical must be within normal range.
- This form is valid for 1 year from the date signed by the Physician.
- All fields must be completed for the form to be valid. Form will be returned if incomplete, resulting in a delay in enrollment.
- Patients meeting current donor criteria may have their blood used for the community blood supply. Go to website: www.carterbloodcare.org for donor eligibility criteria.
- Inclusion of patient's email will speed patient's receipt of scheduling information.

Physician Information: Area for Stamp:

Physician Printed Name: _____

Physician Signature: _____

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

Fax: (_____)_____ Date: _____
Area Code Phone Number

FOR CBC USE ONLY

Donor ID#: _____

Employee Initials: _____ Employee Number: _____ Date: _____

Comments: _____

CBC Medical Director Approval for Phlebotomy: ☐ YES ☐ NO

CBC Medical Director Signature: _____ Date: _____