Carter BloodCare

THERAPEUTIC DONATION REQUEST

Fee will be assessed

Donor Notification Dept.: Phone: (817) 412-5308 (for questions) Fax: (817) 412-5318 Email: DN@carterbloodcare.org

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

Address: _____
Street City State Zip Code

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

Diagnosis: _____

(Reason for the Therapeutic Blood Draw*) ICD Codes are NOT acceptable.

* Patients on Testosterone or with Hereditary Hemochromatosis: Go to carterbloodcare.org for no cost program forms.

- One unit of whole blood to be drawn at each donation. Donations can be 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 Hgb ≥ 13 g/dL. Females are drawn with Hgb ≥ 12.5 g/dL.
- 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 or amended, resulting in a delay in enrollment.

Physician Information: Area for Stamp:

Physician Printed Name: _____

Physician Signature: _____

Phone Number: (_____) _____ Address: _____

Fax: (_____) _____ Date: _____

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: _____