UCLA Health

THERAPEUTIC PHLEBOTOMY PHYSICIAN ORDER

Phone: (310) 794-7207 • Fax: (310) 206-1509

UCLA Blood & Platelet Center

TO BE COMPLETED BY ORDERING PHYSICIAN

PATIENT INFORMATION

Name: _____
Last First Middle

Date of Birth: _____ Gender: ☐ Male ☐ Female
MM/DD/YYYY

Address: _____
(Street, City, State, Zip)

Telephone: _____ Email: _____

Diagnosis: Hereditary Hemochromatosis **Type of Phlebotomy:** Whole Blood [470mL]

Frequency (Select one):

☐ One time only ☐ Weekly ☐ Monthly ☐ Every ___ Weeks ☐ Other (specify): _____

Total Number of Procedures: _____ Expiration Date: _____ Minimum Hemoglobin: _____

ORDERING PHYSICIAN INFORMATION

Physician Name (print): _____
(Street, City, State, Zip)

Office Address: _____

Office Phone: _____ Office Fax: _____

_____ _____ _____
Physician Signature Date Time

UCLA BLOOD & PLATELET CENTER USE ONLY

Order received by: _____ Date received: _____ Donor ID #: _____the____

M.D. or Designee approval: _____ Date approved: _____