NewYork Blood Center

HEMOCHROMATOSIS PHLEBOTOMY PROGRAM

PATIENT ____ SEX ________
(PRINT: FIRST, MIDDLE, LAST NAME)

ADDRESS: __________________________ __________________ ______ ________
(STREET) (CITY) (STATE) (ZIPCODE)

TELEPHONE: WORK (_____) ____________________ HOME (_____) ____________________
(AREA CODE & NUMBER) (AREA CODE & NUMBER)

DATE OF BIRTH: ________________
(mm/dd/yy)

All following fields MUST be completed:

The above patient has been diagnosed with Hereditary Hemochromatosis and is being referred to New York Blood Center for serial phlebotomies in order to deplete his/her iron stores, or maintain low iron stores. The patient understands that he/she will not be charged any fee for this service, but has agreed to donate the drawn blood for transfusion purposes if he/she meets the New York Blood Center's criteria. Furthermore, he/she has agreed that I furnish the following clinical and laboratory information:

Cirrhosis: yes____ no____ Diabetes: yes____ no____ Heart Disease: yes____ no ____

Other Medical Conditions: ____

Current Medications: ____

Hfe Genotype (If known)________________________

Test Date:__________ Serum Iron:_______ TIBC:______ Ferritin:_______ HCT/Hb:______
(mm/dd/yy)

Please draw a 500 ml unit of whole blood (approximately 212 ml red cell loss) every _____________weeks for a total of ______ phlebotomies or double red cell apheresis (approximately 457 ml of red cell loss) blood every _____________weeks for a total of _______ phlebotomies on my patient (**ENTER FREQUENCY FOR BOTH, we do not have apheresis technology at all sites)**, as long as the hemoglobin levels remains above _______ gms./dl.

If my patient desires to help the blood supply even more, it is acceptable to me if he/she undergoes a red cell/ platelet apheresis procedure (255 ml red cell loss) on the whole blood schedule noted above _____ (**MD Initials)**

I understand that I will need to resubmit this form periodically as determined by the NYBC. I will be notified when a new form is required.

PHYSICIAN NAME: ________________________________ PHYSICIAN SIGNATURE:________________________________
(PRINT FIRST, MIDDLE , LAST NAME)

ADDRESS: ____
(STREET, CITY, STATE, ZIP CODE)

TELEPHONE: ________________________________ DATE SUBMITTED: ______________________
(AREA CODE AND NUMBER) (MM/DD/YY)

Fax Completed Form To: Department Of Special Donor and Community Health Services: 212-288-8464 Telephone#: 212-570-3432

NEW YORK BLOOD CENTER

This form remains in effect until_________________ after which a renewal form will be required from the patient's physician
(Date)

MD approval ____ MD SIGNATURE ______________________________________
(PRINT NAME)

DATE Approved ____________________