Versiti Illinois, Inc.
1200 N. Highland Ave.
Aurora IL, 60506

Hereditary Hemochromatosis
Therapeutic Phlebotomy Physician Order

Patient Information:

Name: ____ Date of Birth:_______________________

Address: ____

Telephone Number: ____

Diagnosis: (mark one)
- ☐ Hereditary Hemochromatosis (only diagnosis accepted for therapeutic phlebotomy)
- ☐ Other:____

Frequency of Phlebotomy: (mark one)	Prescription Expiration Date: (mark one)
☐ One Time Only	☐ 12 Months (default and maximum)
☐ Weekly (times ______________Weeks)	☐ Other: ________________________
☐ Monthly (times ______________Months)	
☐ Other: _____________________________	

Phlebotomy Requirements for Therapeutic Donation:

Minimum Hemoglobin: Do NOT draw if Hemoglobin is less than: _________g/dL
- ☐ Whole Blood (default)
- ☐ Double Red Blood Cell Apheresis (if available)

Other Requirements: ______________________________________

Ordering Physician Information:

Print Physician Name: ____

Address: ____

Phone Number: ___________________________________ Fax Number: _________________________

I have evaluated this patient, and am aware of no contraindications to this procedure. I have explained the reason for the procedure to the patient. I will be responsible for the patient's follow up care. **With my signature, I am confirming and verifying the diagnosis listed above.**

Physician's Signature: _____________________________________**Date:** _____________________

Any Questions: Please contact the Donor Management Department for assistance at 630-892-7055

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