

Therapeutic Phlebotomy Patient Registration Form

Instructions: Complete current date and information in Sections 1-3. Incomplete forms cannot be processed. Fax all information to (414) 933-6833.

Current Date: _____

Section 1: PATIENT INFORMATION	
Patient Name (Last, First): _____ DOB (mm/dd/yy): _____	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient Contact Phone #: (____)_____
Diagnosis: (Choose One) <input type="checkbox"/> Hereditary Hemochromatosis* <input type="checkbox"/> Polycythemia Rubra Vera (PRV) <input type="checkbox"/> Porphyria <input type="checkbox"/> Hemochromatosis (other causes) <input type="checkbox"/> Secondary Polycythemia, reason: _____ <input type="checkbox"/> Other: _____	
*If available, please include a copy of the genotyping for patients with a diagnosis of Hereditary Hemochromatosis: <input type="checkbox"/> Pending, if applicable <input type="checkbox"/> Other: _____	
Section 2: CURRENT LABORATORY DATA	
<ul style="list-style-type: none"> Please include a copy of the patient's current H&P and medication list with all requests. If this information is not included with this request, this order cannot be processed. Versiti will not accept a prescription for a patient with Hgb less than 12 g/dL If Ferritin is less than 50 ng/mL, the patient may not be phlebotomized more than once every two months. 	
Date of Labs (mm/dd/yy): _____	
Hgb: _____	Ferritin: _____ % Saturation: _____
Section 3: PHYSICIAN INFORMATION	
Ordering Physician Name: _____	
Physician Contact Phone #: (____)_____ Physician FAX #: (____)_____	

Fax all information to (414) 933-6833 or email to SPSAlerts@versiti.org

New forms may be obtained by visiting:
 www.versiti.org → Medical Professionals → Specialty Products & Services → BloodCenter of Wisconsin → Therapeutic Phlebotomy

VERSITI PHYSICIAN USE ONLY	
<input type="checkbox"/> Phlebotomy Approved	<input type="checkbox"/> Phlebotomy Denied
Blood Unit Approved for use in General Inventory: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Versiti Physician Signature: _____	Date: _____