36358 GARFIELD RD.
STE #3
CLINTON TWP, MI 48035

Request for Therapeutic Phlebotomy

FAX COMPLETED REQUEST TO: 586-421-4842 or Email To: help@infoonestopsc.com

For questions, call 586-350-0900.

Patient's Full Legal Name:	Date of Birth: Telephone #:

All patients must call 586-350-0900 to verify order receipt.

Please allow up to 3 business days for processing.

Diagnosis - Reason for Phlebotomy	☐ Secondary Polycythemia due to **Testosterone Replacement Therapy** D75.1	☐ Hereditary Hemochromatosis E83.110
	☐ Secondary Polycythemia, other D75.1	☐ Other Hemochromatosis E83.118
	☐ Polycythemia Vera D45	☐ Other *(Include both ICD-10 Code and Diagnosis)*:
Minimum Hematocrit for Phlebotomy	**FOR Polycythemia** ☐ 45% ☐ Other: _____	**FOR Iron unloading (Hemochromatosis)** ☐ 33% (minimum) ☐ Other: _____
	HCT will be performed before each phlebotomy. No CBC or ferritin testing provided	
Frequency (Whole Blood 500 +/- 50 mL)	Required: ☐ One time ONLY *Or* ☐ Every _____ week(s)	
	Optional: ☐ Hold collections after _____ # of collections - Request will expire once filled	
Patient History	Does your patient have any medical contraindications or risks for phlebotomy? ☐ **No** ☐ **Yes (If yes, explain)**	

Physician Information (all fields are mandatory):	
Physician's Signature:	Date:
Printed Name:	Telephone #:
Full Mailing Address:	Fax #:

Therapeutic patients by appointment ONLY.