Blood Bank of Alaska
Helping Alaska patients in need

1215 Airport Heights Dr. • Anchorage, AK 99508 • Tel: 907-222-5600 • Fax: 907-563-1371 • www.bloodbankofalaska.org

Provider's Request for Therapeutic Phlebotomy

Patient Information	
Patient Name:	DOB:
Telephone:	SSN:

Requesting Provider's Information		
Name of Office:		
Requesting Provider:		Select One: ☐ MD or DO ☐ APRN ☐ PA-C
Office Telephone:	Office Fax:	

Reason for Request (Diagnosis):

☐ Hemochromatosis
☐ Increased ferratin
☐ Polycythemia/erythrocytosis
☐ Polycythemia/erythrocytosis, secondary to testosterone therapy
☐ Polycythemia vera
☐ Other (*Please specify*):

Patient Blood Collection

Blood Bank of Alaska collects one unit of blood at each patient visit. One unit is equivalent to 500 mL of blood. Blood Bank of Alaska does not accommodate requests for alternate collection volumes.

Minimum Pre-Donation Hematocrit (%):

Please be aware that BBA is required to adhere to any prescribed hematocrit limits. If your patient presents with a hematocrit value that is out of range as indicated here or on a prescription, they will be deferred for one day.

Frequency of Phlebotomy (*check one*):

☐ Weekly ☐ Monthly ☐ Other (*Please specify. PRN is not an acceptable frequency.*):

Comments:

Duration of Request (*must not exceed one year without re-evaluation*):

Your signature below indicates you have determined your patient is sufficiently healthy for therapeutic phlebotomy.

Signature of Requesting Provider (MD, DO, APRN, or PA-C):	Date:

BBA Staff Use	
LifeTrak Data Entry By	LifeTrak Data Entry Reviewed By
Initials: Date:	Initials: Date: