



Physician's Request for Therapeutic Blood Collection

Patient Information		
Patient's Name:		BBCS Patient #:
Telephone:	DOB:	SSN:
Requesting Physician Information		
Name of Office:		
Requesting Physician:		
Office Telephone:	Office Fax:	
Reason for Request (Diagnosis):		
Patient Blood Collection		
Amount of blood requested (mL):		
<input type="checkbox"/> 500 mL (1 unit) <input type="checkbox"/> Other (please specify; <i>not to exceed 500 mL</i> ):		
Minimum Pre-Donation Hematocrit (%):		
Frequency of Phlebotomy (Check one.):		
<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (please specify):		
Comments:		
Duration of Request (must not exceed one year without re-evaluation):		
Signature of Requesting Physician:		Date:
BBA Staff Use		
BBCS Review by:		Date: