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

Physician's Request for Therapeutic Blood Collection

Patient Information	
Patient Name:	DOB:
Telephone:	SSN:
Requesting Physician Information	
Name of Office:	
Requesting Physician:	Select one: ☐ MD or DO ☐ ANP or PA-C
Office Telephone:	Office Fax:
Reason for Request (Diagnosis):	
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 is not able to accommodate any requests for alternate collection volumes.	
Minimum Pre-Donation Hematocrit (%):	
Frequency of Phlebotomy (*check one*): ☐ Weekly ☐ Monthly ☐ Other (*Please specify. PRN is not an acceptable frequency.*):	
Duration of Request (*must not exceed one year without re-evaluation*):	
Comments:	
Signature of Requesting Physician (MD or DO):	Date:
Requests from ANP or PA-C	
BBA requires submission of documentation sufficient to substantiate diagnosis for which phlebotomy is intended. Medical Director review and approval is required before phlebotomy is performed for orders from an ANP or a PA-C.	
Signature of Requester (ANP or PA-C):	Date:
BBA Staff Use	
Medical Director Review Therapeutic phlebotomy may proceed: ☐ Yes ☐ No If no, referring physician notification by (initials): _____	
Additional Comments:	
Medical Director Signature:	**Date:**
LifeTrak Data Entry By	Review of LifeTrak Data Entry By
Initials: Date:	Initials: Date: