

## HEREDITARY HEMOCHROMATOSIS ONE TIME VERIFICATION

To the Physician: This is not an order. This is to allow your patient to donate as a		
community blood donor. Frequency of phlebotomy required is 8 weeks (56 days) or more.		
Minimum Hemoglobin: Male: 13.0 g/dL Female: 12.5 g/dL		
Fax completed form to 909-386-6817		
For assistance contact Special Services Department at 1-877-386-6874		
Patient Information		
Patient Legal	Patient Legal	
Last Name	First Name	
Patient	Birth Sex	
Address	Patient Date (circle one)	
	of Birth M F	
Patient Phone	Patient	
Number	Email	
Physician Information (must be MD/DO, ND, NP or PA and licensed in US)		
Physician	Physician	
Name/Credentials	Phone Number	
Physician	Physician Fax	
Address	Number	
Patient Diagnosis		
Hereditary Hemochromatosis (confirmed by HFE C282Y mutation analysis or liver biopsy)		
<b>Provider Signature</b> (Note: Requests with practitioner's name signed by another individual, initialed or with a stamped signature will be returned for authorized signature.)		
I have evaluated this patient and I confirm patient as aforementioned diagnosis. I will be responsible for		
the patient's follow-up care. With my signature I am confirming and verifying the diagnosis listed above.		
Provider Signature:	Date:	
Note: If frequency of phlebotomy required is less than 8 weeks (56 days) or minimum hemoglobin is greater than our minimums Male: 13.0 g/dL Female: 12.5 g/dL, please submit a therapeutic phlebotomy physician order.		
https://www.lstream.org/hospitals-physicians/physician-services/		



## (PLEASE GIVE THE BELOW INFORMATION TO YOUR PATIENT)

## IMPORTANT THINGS YOU SHOULD KNOW ABOUT YOUR THERAPEUTIC PHLEBOTOMY

- 1. LifeStream's Special Services Department <u>will contact you **AFTER** we receive</u> the verification form from your physician.
- 2. Please drink plenty of fluids and eat well before your appointment
- 3. If you have any questions regarding this process, please contact LifeStream's Special Services Department at 1-877-386-6874.