LifeStream Blood Bank
CASCADE REGION

HEREDITARY HEMOCHROMATOSIS ONE TIME VERIFICATION

To the Physician – the purpose of this form:

- If you complete/submit this Hereditary Hemochromatosis (HH) one-time verification form and your patient meets criteria, your patient will be able to donate as a community blood donor without having to be scheduled as a therapeutic blood draw through our Special Services department.

Criteria for HH donors to donate as a community blood donor:

- Frequency of phlebotomy required is every 8 weeks (56 days) or more.
- Acceptable Hemoglobin Range: Male: 13.0 – 20.0 g/dL; Female: 12.5 – 20 g/dL
- Must meet all other allogenic criteria at the time of donation

Note: If your patient does not meet criteria/is deferred, please submit a therapeutic phlebotomy physician order (https://www.lstream.org/hospitals-physicians/physician-services/ so that we can schedule them through our therapeutic program.

- Fax completed form to 909-386-6817
- For assistance contact Special Services Department at 1-877-386-6874

Patient Information

Patient Legal Last Name		Patient Legal First Name		
Patient Address		Patient Date of Birth		Birth Sex (circle one) **M F**
Patient Phone Number		Patient Email		

Physician Information (*must be MD/DO, ND, NP or PA and licensed in US)*

Physician Name/Credentials		Physician Phone Number	
Physician Address		Physician Email and/or Fax Number	

Patient Diagnosis *(check box below to verify patient's diagnosis)*

☐	**Hereditary Hemochromatosis** - confirmed by HFE genotyping as homozygous C282Y/C282Y.
☐	**Hereditary Hemochromatosis** - confirmed by HFE genotyping as homozygous H63D/H63D.
☐	**Hereditary Hemochromatosis** - confirmed by HFE genotyping as compound heterozygous C282Y/H63D.

Provider Signature (*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/

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(PLEASE GIVE THE BELOW INFORMATION TO YOUR PATIENT)

IMPORTANT THINGS YOU SHOULD KNOW ABOUT YOUR THERAPEUTIC PHLEBOTOMY

1. LifeStream's Special Services Department will contact you **AFTER** we receive 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.