Community Blood Council of New Jersey, Inc.
1410 Parkside Avenue
Trenton, NJ 08638

REQUEST FOR HEREDITARY HEMOCHROMATOSIS PHLEBOTOMY

Donor Name: _____Sex: _____

Address: _____
(Street) (City) (State) (Zip)

Phone: _____SS#: _____ Birth Date: _____
(Home) or (Work)

Diagnosis: (check one)

□ Hereditary Hemochromatosis □ Other Medical Problems: _____

_____

Physician Information:

Physician's Name: _____

Phone Number: _____Fax Number: _____

Minimum Hemoglobin for Phlebotomy: _____ gm/dl

Collection: □ 500mL Whole Blood □ Double Red Cell (Apheresis)

Frequency of Phlebotomies: _____ (no more frequent than one-week intervals)

Physician Signature: _____Date:_____

Note: This prescription is only valid for 6 months.

Fax completed information above to: Penny Moyer, Donor Services Director at 609 883-3570
Phone: 609 883-9750 Ext. 117

Revised PM 02/01/2013

COMMUNITY BLOOD COUNCIL OF NEW JERSEY, INC.
Trenton, NJ 08618

HEMOCHROMATOSIS PHLEBOTOMY INFORMED CONSENT

Donor Name: _____

The above donor has been diagnosed with hemochromatosis and is being referred to the Community Blood Council of New Jersey for phlebotomies in order to deplete his/her excess iron storages, or maintain low iron storages. The donor is aware that there will be **no charge** for any hemochromatosis donations even if the donor does not qualify to be a routine blood donor after a history, physical examination or routine infectious disease testing. This applies to all donors with hemochromatosis whether they are referred by a physician or self referred.

_____ _____
Donor Signature Date

Print Name: _____

_____ _____
Phlebotomist Date

Blood Center's Medical Director's Review: _____Date_____