HEREDITARY HEMOCHROMATOSIS, TESTOSTERONE TREATMENT AND THERAPEUTIC PRESCRIPTION ORDER

To the Physician:

- A prescription is required:
  - for patients with elevated hemoglobin due to hereditary hemochromatosis or prescription testosterone treatment
  - when blood collection is medically recommended for patients with other medical conditions who do not meet allogeneic donor eligibility criteria
- Prescriptions for:
  - serial collections are valid for one (1) year from the date written unless otherwise specified in Comments section (i.e. one time prescription or for a shorter period of time)
  - patients with elevated hemoglobin due to hereditary hemochromatosis or prescription testosterone treatment must contain frequency, diagnosis and hemoglobin for the patient to be collected more frequently than every 56 days
- Donated blood from patients with elevated hemoglobin due to hereditary hemochromatosis (HH) or prescription testosterone treatment (TT) who meet all allogeneic donor eligibility requirements may be used as transfusable blood products
- Blood collected from patients not meeting allogeneic donor eligibility criteria is discarded after collection

DONOR INFORMATION

Last Name		**First Name**	
Date Of Birth		**Phone**	

PHYSICIAN INFORMATION

Name		**Phone**	
Address		**Fax**	

PLEASE INDICATE DIAGNOSES BELOW:

❒	**Hereditary Hemochromatosis (HH)**	❒	**Elevated hemoglobin due to prescription testosterone treatment (TT)**
List other diagnoses >			

FREQUENCY OF PHLEBOTOMY

If frequency is not indicated below, HH and TT donors may only be drawn once every 56 days. Therapeutic donors may be drawn once every 2 days provided other prescription and eligibility requirements are met. If frequency written as monthly, donor may be drawn every 28 days. (see "To the Physician" for additional information)

❒	**One Time Only**	❒	**Every 2 weeks**	❒	**Every 8 weeks**
❒	**Weekly**	❒	**Every 4 weeks**	**Other frequency >**	

HEMOGLOBIN

Hgb must be a minimum 11.0 g/dL to be collected

Do not perform phlebotomy if donor's <u>hemoglobin</u> is less than	_____	**g/dL**

AMOUNT TO BE DRAWN

If the volume to collect is not indicated, the collection target will be proportional to the donor's weight, not to exceed 500 mL

❒	**One unit of whole blood** (approximately 500 mL)	**Other amount >**	_____	**mL**
Comments				

Signature of Physician *(or Authorized Medical Professional Requesting Collection)*		**Date**	

ONEBLOOD PRESCRIPTION REVIEW & ENTRY

❒	All required Rx requirements present AND entered in RSA	**Badge ID**	
❒	All required Rx requirements NOT present AND Physician/Donor Contacted	**Date**	