Western Cape Blood Service
Do something remarkable

REQUEST FOR THERAPEUTIC PHLEBOTOMY

(FOR COMPLETION BY THE REFERRING CLINICIAN)

PATIENT DETAILS	
First name	**Title**
Surname	
Email address	
ID/Passport number:	**Date of birth:**
Cell phone number:	**Age** (new donors must be under 75 years of age):

WCBS does <u>not</u> accept first-time donors (therapeutic or regular donors) over the age of 75 years.
Phlebotomy is only performed when the haemoglobin level is >12,5g/dL.
All requests are reviewed and authorised by the Head of the Medical Division at WCBS.
It is not appropriate for ill or frail patients to be bled at WCBS clinics as these are non-medical facilities.
No additional samples for processing at external laboratories may be taken by WCBS staff.

Enrolment for therapeutic phlebotomy is required when patients <u>do not</u> meet acceptance criteria for regular blood donation. Enrolment would be required under the following circumstances:

1. When a phlebotomy interval <u>more frequent</u> than every 56 days (routine blood donation interval) is prescribed.
2. When the patient has polycthaemia vera or high affinity haemoglobin as these diagnoses do not meet acceptance criteria.
3. When the patient's medical or lifestyle history does not meet routine donation acceptance criteria e.g. Warfarin or Methotrexate use, cancer, testosterone use for body building purposes etc.

Please note: patients are charged for phlebotomy if their blood is not able to be used for transfusion purposes.

PLEASE ONLY COMPLETE THE SECTION BELOW RELEVANT TO THE PATIENT'S DIAGNOSIS.

HYPERFERRITINAEMIA

Ferritin:	Date:

If ferritin is **> 1000 ug/L**, please provide the latest available liver enzyme results.

ALT: ALP: AST: GGT: Date:

PCR for Haemochromatosis (mark 'x or ✓' where relevant)

C282y Homozygote		C282y Heterozygote		PCR for Haemochromatosis negative	
H63D Homozygote		H63D Heterozygote		PCR for Haemochromatosis not performed	
S65C Homozygote		S65C Heterozygote			

If the PCR for Haemochromatosis was negative or not performed, please complete the section below.

Please indicate suspected cause of raised ferritin level:

Has underlying infection or inflammation been excluded by inflammatory marker testing (ie. CRP/ESR)?	Yes No (circle)
If no, is there any clinical suspicion of underlying infection, inflammation or malignancy?	Yes No (circle)

SECONDARY POLYCYTHAEMIA (mark 'x or ✓' to indicate the underlying cause)

Testosterone replacement therapy		Testosterone for body building purposes		Hb: HCT:
Smoking		Sleep apnoea		
COPD		Idiopathic		Date:

HIGH AFFINITY HAEMOGLOBIN

Indicate test(s) performed (in addition to FBC) to determine the diagnosis e.g. p50 etc.	Hb: HCT: Date:

POLYCYTHAEMIA VERA

Indicate test(s) performed (in addition to FBC) to determine the diagnosis e.g. JAK2, bone marrow biopsy etc.	Hb: HCT: Date:

MEDICAL AND SURGICAL HISTORY
Note: A formal medical report must be attached for any patient with cardiac comorbidity.
If your patient is older than 70 years or is frail, oxygen dependent or has any condition affecting their memory or mobility, please elaborate.

CHRONIC MEDICATIONS

PRESCRIPTION - TO BE COMPLETED BY THE CLINICIAN	
This patient should receive phlebotomy every ☐ week(s). **Please note:** 1. A maximum of 8 phlebotomies will be permitted at this interval. Following this, the patient will revert to the routine donation interval (56 days) unless an updated prescription is sent by the Clinician to WCBS (phlebotomy@wcbs.org.za). 2. Adherence to the phlebotomy interval is a responsibility that lies with the patient and the Clinician. WCBS staff are not responsible for reminding patients of their phlebotomy schedule. 3. The Clinician remains responsible for the patient's medical management and phlebotomy interval.	
First name:	Surname:
Contact number:	Practice number:
Address:	
Email address:	
I certify that it is safe for this patient to donate ± 450 ml blood at the intervals prescribed. I do not anticipate any untoward reaction from the phlebotomy procedure and agree that phlebotomies can take place at a donation centre with limited medical support.	
Date:	Signature:

TO BE COMPLETED BY WCBS HEAD – MEDICAL DIVISION OR LEAD MEDICAL CONSULTANT					
Site of first donation (circle)	Regular clinic	HQ	Blood for use at first therapeutic donation (circle)	Yes	No
To be assessed by Head - Medical Division/ Lead Medical Consultant at HQ (circle)	Yes	No	Blood for use at subsequent donations (circle)	Yes	No
Comments:					

Signature:	Date:	Number of previous valid donations:

For office use	Donor code												