**R&B Labs Mobile Phlebotomy Services**  
**Therapeutic Phlebotomy Request Form**

**Complete and fax or email to**   
[**Fax:**](mailto:Fax:) **(718) 734-2499 |** [**info@rbmobilelabs.com**](mailto:info@rbmobilelabs.com)

**Patient Information:**

* **Full Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age:** \_\_\_\_\_\_\_\_\_\_\_
* **Gender:** ☐ Male ☐ Female ☐ Other
* **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician Information:**

* **Referring Physician Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Physician’s Office Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Fax Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **NPI:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Information:**

* **Diagnosis Requiring Therapeutic Phlebotomy:**  
  ☐ Polycythemia Vera  
  ☐ Hemochromatosis  
  ☐ Porphyria Cutanea Tarda  
  ☐ Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Hemoglobin Level:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ g/dL (within 24 hours)
* **Hematocrit Level:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% (within 24 hours)
* **Serum Ferritin Level:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ng/mL (if applicable)

**Procedure Information:**

* **Volume to be Removed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ mL
* **Frequency of Procedure:**  
  ☐ One-Time  
  ☐ Weekly  
  ☐ Bi-Weekly  
  ☐ Monthly  
  ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_