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

**Complete and fax or email to**
**Fax:** **(718) 734-2499 |** **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_