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

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