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

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