Western Cape Blood Service
Do something remarkable

REQUEST FOR THERAPEUTIC PHLEBOTOMY

(FOR COMPLETION BY THE REFERRING CLINICIAN)

PATIENT DETAILS	
First name:	**Surname:**
ID number:	**Cell number:**
Email address:	

All requests are reviewed 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.
Phlebotomy is only performed when the haemoglobin level is ***>12.5g/dL****.*
WCBS does not accept first-time donors over the age of ***75 years****.*
No additional samples for processing at external laboratories may be taken by WCBS staff.

Please provide the following information in order for WCBS to determine whether or not the patient's blood may be used for transfusion purposes. Please note: patients are charged for phlebotomy if their blood is not used due to the referring diagnosis or not meeting other WCBS donation criteria.

PLEASE COMPLETE THE SECTION RELEVANT TO THE PATIENT'S DIAGNOSIS

Hereditary Haemochromatosis (HH) (tick where relevant)

C282y Homozygote		C282y Heterozygote		Ferritin:
H63D Homozygote		H63D Heterozygote		
S65C Homozygote		S65C Heterozygote		Date:

If ferritin is > **1000 ug/L** , please provide liver enzyme results. Comments:	ALT: ALP: AST: GGT: Date:

Raised Ferritin (tick where relevant)

HH PCR test not done		HH PCR test negative		Ferritin:
Underlying cause of raised ferritin:				Date:

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

Secondary Polycythaemia (tick where relevant)

Testosterone use		COPD		Hb: HCT:
Smoking		Sleep apnoea		
Other cause:				Date:

High Affinity Haemoglobin

How was the diagnosis made?	Hb: HCT: P50 result: Date:

Polycythaemia Vera

How was the diagnosis made ?	Hb: HCT: JAK 2: Bone marrow biopsy: Date:

MEDICAL AND SURGICAL HISTORY
Note: A formal medical report should be attached for any patient with cardiac comorbidity.
If your patient is older than 70 years, frail, oxygen dependent or reliant on any walking equipment, please elaborate.

CHRONIC MEDICATIONS

PRESCRIPTION - TO BE COMPLETED BY THE CLINICIAN	
This patient should be venesected every ☐ week(s) for a total of ☐ phlebotomies. Following this, the patient will revert to a maximum of one phlebotomy every 8 weeks unless an updated prescription is sent by the clinician to the Therapeutic Phlebotomy Service (phlebotomy@wcbs.org.za).	
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 CEO/ MEDICAL DIRECTOR												
Site of first donation (tick)	Regular clinic	HQ	To be assessed by Head-Medical Division or CEO/Medical Director at HQ (tick)	Yes	No							
Blood for use at first therapeutic donation (tick)	Yes	No	Blood for use at subsequent donations (tick)	Yes	No							
Comments:												
Signature:			Date:									
For office use	**Donor code**											

WCBS Specialised Donations: Tel: (021) 507 6393 or (021) 507 6320 | Fax: (021) 531 3335 | Email: phlebotomy@wcbs.org.za