



**COMMUNITY BLOOD COUNCIL
OF NEW JERSEY, INC.**

1410 Parkside Ave. | Trenton, NJ 08638 | 609.883.9750

REQUEST FOR HEMOCHROMATOSIS PHLEBOTOMY

Donor Name: _____ SEX : _____

Address: _____
(Street) (City) (State) (Zip)

Phone: _____ SS#: _____ Birth Date: _____
(Home) or (Work)

Diagnosis: (check one) Hemochromatosis Other medical problems _____

Physician Information:

Physician's Name: _____

Phone Number: _____ Fax Number: _____

Minimum HgB for Phlebotomy: _____ gms/dl (can not be less than 12.5 gms/dl)

Collection: 450mL Whole Blood 500mL Whole Blood Double Red Cell (Apheresis)

Frequency of Phlebotomies: _____ (no more frequent than one-week intervals)

Physician Signature: _____ Date: _____

Note: This prescription is only valid for 6 months.

Fax completed information above to: Penny Moyer, Donor Services Director at 609 883-3570
Phone: 609 883-9750, ext. 117