Carter BloodCare

ENROLLMENT/PRESCRIPTION FOR NO-FEE PHLEBOTOMY FOR TESTOSTERONE REPLACEMENT THERAPY (TRT) PATIENTS ONLY

Please allow 3-5 business days for processing

Contact Us: FAX: (817) 412-5609 Email: DN@carterbloodcare.org Phone: (817) 412-5603

Patient Information (Please use patient's legal name and complete address.):

Full Name: _____ _____ Sex: _____ DOB: _____
Last Name First Name

Address: _____ Phone #: (_____)_____
Area Code Phone Number

_____ ____ _____ _____
City State Zip Email

Testosterone Therapy Needing Phlebotomy

- Patient will be drawn as long as Hgb is 13 g/dL or higher.
- Patients meeting current donor criteria may have their blood used for the community blood supply.
- Once enrolled, the patient will receive an email or letter with scheduling information.
- This form is valid for 1 year from the date signed or until a frequency update is required.

Approximately 500 mL (1 unit) of whole blood will be drawn at each donation.

This form is only required if the patient needs to be drawn more frequently than every 8 weeks **OR** if the patient will not meet blood donor criteria. If neither of the above is applicable, please direct them to any Donor Center or mobile drive.

For patients needing more frequent phlebotomy choose only from the available boxes below. Additional comments will void the form and it will be returned.

Patient can be drawn as frequently as:

☐ Every 4 weeks ☐ Every 2 weeks

(Patient may schedule less frequent intervals as needed or as directed by the provider)

Physician Information:

Physicians Signature: _____ Date: _____

Physicians Printed Name: _____

Phone #: (_____)_____ Fax #: (_____)_____
Area Code Phone Number Area Code Phone Number

FOR CBC USE ONLY – Cardiac/Medical Clearance

Donor ID#: DN_____ Cardiac Clearance Release Received Date: _____ Employee Initial/Date: _____

Comments: _____

Carter BloodCare Medical Director Approval for Phlebotomy: ☐ YES ☐ NO

CBC Medical Director Signature: _____ Date: _____

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