NewYork Blood Center

Hereditary Hemochromatosis Phlebotomy Program Referral Form

PATIENT_____ **GENDER** ☐ **M** ☐ **F** **DATE OF BIRTH**_____
(FIRST, MIDDLE, LAST NAME) (mm/dd/yy)

ADDRESS _____ _____ _____ _____
(STREET) **(CITY)** **(STATE)** **(ZIPCODE)**

TELEPHONE: WORK_____ HOME _____ CELL _____
(AREA CODE & NUMBER) (AREA CODE & NUMBER) (AREA CODE & NUMBER)

General Recommendations for Management of Hereditary Hemochromatosis

- For iron depletion, weekly or biweekly whole blood phlebotomy for a total of 10-12 phlebotomies with a serum ferritin goal of 50-100 ng/mL
- Once ferritin goal is achieved, maintenance phlebotomy schedules should be implemented. Because iron re-accumulation rates vary, frequency of maintenance phlebotomy should be tailored individually to maintain a ferritin of 50-100 ng/mL; this may involve between 2 and 12 phlebotomies per year.
- Pre-phlebotomy hemoglobin or hematocrit should remain normal because the goal of phlebotomy is to achieve low normal iron stores, not iron deficiency or anemia.
- Excessively frequent phlebotomies resulting in ferritin below 50 ng/mL may increase iron absorption in patients with Hereditary Hemochromatosis and therefore are not advisable.

Please refer to Bacon BR *et al* 2011 *Hepatology* for complete Practice Guidelines.

All following fields MUST be completed (incomplete forms will not be accepted):

The above patient has been diagnosed with Hereditary Hemochromatosis, a genetic disease, and is being referred to New York Blood Center for serial phlebotomies in order to deplete his/her iron stores, or maintain low iron stores. The patient understands that he/she will not be charged any fee for this service, but has agreed to donate the drawn blood for transfusion purposes if he/she meets the New York Blood Center's criteria. Furthermore, he/she has agreed that I provide the following laboratory information:

Most recent ferritin value: _____ Test Date:_____

Request: Pre-phlebotomy hemoglobin value must be at least _____ g/dl to enable donation on that day.

Please draw a 500 ml unit of whole blood donation (approximately 232 ml red cell loss) every _____ weeks for a total of _____ phlebotomies.

I understand that I will need to resubmit this form periodically as determined by NYBC. I will be notified when a new form is required.

All following information MUST be completed:

PHYSICIAN NAME: _____ PHYSICIAN SIGNATURE: _____
(PRINT FIRST, MIDDLE , LAST NAME)

ADDRESS: _____
(STREET, CITY, STATE, ZIP CODE)

TELEPHONE: _____ DATE SUBMITTED: _____
(AREA CODE AND NUMBER) (MM/DD/YY)

Fax Completed Form to Department of Special Donor Services: 212-288-8464 Telephone#: 212-570-3432

NEW YORK BLOOD CENTER

MD name: _____ MD SIGNATURE _____DATE Approved _____