

Therapeutic Venesection Review Form

This form is to be used for patients who have **previously been approved** for therapeutic venesection with the Australian Red Cross Blood Service (the Blood Service). For new referrals please refer to the *Therapeutic Venesection Information and Request Form*.

The referring doctor must complete this form in the following circumstances:

- At the time of the requested review (at least annually) for those patients attending more frequently than 12 weekly
- If the patient has a non-haemochromatosis condition for which therapeutic venesections are indicated
- If venesection frequency increases to more often than once every twelve weeks
- If there are significant changes in patient's health

Patient Name: Date of Birth

Address: Phone Home

..... Work

DONOR REGISTRATION NUMBER (BLOOD SERVICE OFFICE USE ONLY):.....

Please do not attach any results.

Required venesection frequency and review interval. Must complete	
Other medical conditions (please specify)	
Minimum acceptable Hb (Blood Service standard minimum Hb will apply if this is not completed)	<input type="checkbox"/> 120g/L (standard female minimum) <input type="checkbox"/> 130g/L (standard male minimum) <input type="checkbox"/> otherg/L (<i>Absolute Blood Service minimum is 100 g/L for therapeutic venesection</i>)

I hereby request therapeutic venesection for the above patient who is under my clinical care.

- I understand that my patient must continue to meet the Blood Service criteria for the Blood Service therapeutic venesection programme.
- I am aware that the Blood Service will not be held responsible if my patient does not attend for venesection.
- I am aware that I will be responsible for monitoring the patient and advise the Blood Service of changes to the venesection schedule or the patient's health.
- I will provide regular ongoing clinical review and referrals as required above.

The maximum volume of blood removed at each venesection will be 500mL. This includes the collection and routine samples for mandatory testing.

Doctor's name _____ Doctor's signature _____

Doctor's address _____

Phone: _____ Fax: _____ Date: _____

Thank you for your assistance in this matter.

Please return this form to:

Medical Officer, Australian Red Cross Blood Service, GPO Box B80, Perth, WA 6838 or fax (08) 9221 5732 or email medoffenq@redcrossblood.org.au

APPROVED BY (THE BLOOD SERVICE STAFF).....	DATE:.....
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Privacy Statement:

The personal information collected on this form allows the patient to be registered and enrolled as a Blood Service therapeutic donor, and for the person to be registered to provide blood for clinical use when donor selection guidelines are met. All information collected will be handled in the strictest confidence in accordance with Federal Privacy Law.