

# Therapeutic Venesection Information and Request Form

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## INFORMATION FOR REQUESTING DOCTORS

The Australian Red Cross Blood Service (the Blood Service) offers a therapeutic venesection service to patients with medical conditions for which regular venesection is considered beneficial.

### 1. To be eligible the patient must have:

a. Evidence of genetic /hereditary haemochromatosis:

- Homozygosity for the known HFE gene mutations (C282Y, H63D) OR
- Compound heterozygosity for the known HFE mutations e.g. C282Y/H63D OR
- Comprehensive iron studies, ferri-scan or liver biopsy consistent with haemochromatosis OR

b. Clinical evidence of iron overload (elevated transferrin saturation with or without elevated ferritin or iron) in the absence of other disease OR

*One of the conditions below, following referral by or in consultation with a specialist:*

- c. Polycythaemia rubra vera OR
- d. Porphyria cutanea tarda

### 2. The Blood Service guidelines for donor safety must be met.

As the Blood Service does not provide medical supervision, all donors must fulfill the Blood Service donor safety guidelines.

### 3. The patient must be free from hepatitis B, hepatitis C and HIV. In patients with abnormal LFT, infections with HBV and HCV should be excluded before referral.

### 4. Therapeutic donors must be monitored by the referring doctor

- It is the responsibility of the referring doctor to clinically monitor the patient and advise the Blood Service of any changes to the venesection intervals or significant changes to the patient's health.

### 5. The referring doctor must complete this form for initial referral.

### 6. Donor and product safety

- The Blood Service is responsible for therapeutic collection and monitoring safety during the venesection procedure.
- The Blood Service will inform both the patient and the referring doctor if at any time the patient is assessed as not meeting Blood Service criteria for therapeutic donor selection.
- The Blood Service reserves the right to refuse to venesect if there is concern for patient safety.
- The blood donation will be used in clinical or derivative products only if the donor selection guidelines for clinical use are met.
- The Blood Service will not accept responsibility if the patient does not attend for venesection.

If you are uncertain regarding your patient's eligibility or require assistance with a donation schedule please do not hesitate to call our Medical Officers on (08) 9421 2814.

# Therapeutic Venesection Information and Request Form

Patient Name: ..... Date of Birth .....

Address: ..... Phone Home .....

..... Work .....

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

**PLEASE COMPLETE ONE SECTION ONLY**

**Section 1 - Complete if your patient has one of the following conditions. Complete this section for new referrals:**

- Haemochromatosis as evidenced by **homozygous or compound heterozygous (i.e. heterozygous for more than 1 HFE gene) HFE gene testing**
- Iron overload as evidenced in blood studies (elevated transferrin saturation)
- Iron overload as evidenced by liver biopsy, or other diagnostic method

The following conditions should be referred by, or in consultation with, a specialist. Please provide supporting documentation confirming diagnosis. If a specialist is not involved with care, please call our Medical Officers on (08) 9421 2814 prior to referral.

- Polycythaemia rubra vera
- Poryphyria cutanea tarda

**Please attach copies of relevant investigations (gene studies, iron studies, FBC etc) and complete table below:**

<b>Required venesection frequency and review interval. Must complete</b>	.
<b>Other medical conditions (please specify)</b>	
<b>My patient has an abnormal LFT and has been tested for hepatitis B and hepatitis C</b>	<input type="checkbox"/> Negative (attach results) <input type="checkbox"/> Positive (not eligible for venesection at the Blood Service) For patients found positive on subsequent Blood Service testing, the results will be sent to the referring doctor for notification and counselling of the patient.
<b>The cause of my patient's abnormal LFT</b> (if applicable)	
<b>Minimum acceptable Hb</b> (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"/> other .....g/L ( <i>Absolute Blood Service minimum is 100 g/L for therapeutic venesection</i> )

# Therapeutic Venesection Information and Request Form

Patient Name: ..... Date of Birth .....

Address: ..... Phone Home .....

..... Work .....

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

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

- I understand that my patient must meet the Blood Service criteria for acceptance in 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. If there is indication to vary this amount, please contact and discuss with a Blood Service Medical Officer.

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 [medoffeng@redcrossblood.org.au](mailto:medoffeng@redcrossblood.org.au)

APPROVED AS THERAPEUTIC DONOR BY (THE BLOOD SERVICE STAFF).... DATE:.....

**Privacy Statement:**

The personal information collected on this form allows the patient to be registered and enrolled as a Blood Service therapeutic or normal whole blood 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.

# Therapeutic Venesection Information and Request Form

Patient Name: ..... Date of Birth .....  
 Address: ..... Phone Home .....  
 ..... Work .....

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

**PLEASE COMPLETE ONE SECTION ONLY**

## Section 2 - Complete if your patient does not meet the criteria in section 1.

Patients with a raised serum ferritin without a diagnosis of haemochromatosis (including those heterozygote for a single HFE gene) or an acquired iron overload condition are **not eligible** to be accepted into the **Blood Service therapeutic venesection program**.

However, if other causes of raised ferritin have been excluded, such as malignancy, significant liver disease, chronic systemic or inflammatory disease or autoimmune disease, the person may be eligible to become a regular whole blood donor, donating at intervals of 12 weeks or more.

**Raised serum ferritin only** - may be eligible as regular blood donor if chronic systemic or inflammatory disease, significant liver disease, autoimmune disease and malignancy can reasonably be excluded.

Is there any evidence of?

	yes	no	Details
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic systemic disease/inflammation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Malignancy	<input type="checkbox"/>	<input type="checkbox"/>	_____

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](mailto:medoffenq@redcrossblood.org.au)

APPROVED AS NORMAL BLOOD DONOR BY (THE BLOOD SERVICE STAFF)..... DATE:.....

**Privacy Statement:**

The personal information collected on this form allows the patient to be registered and enrolled as a Blood Service therapeutic or normal whole blood 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.

# Therapeutic Venesection Information and Request Form

Patient Name: ..... Date of Birth .....

Address: ..... Phone Home .....

..... Work .....

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

**PLEASE COMPLETE ONE SECTION ONLY**

### Section 3 – Complete if your patient is a HFE gene carrier with normal iron studies and wishes to be a normal blood donor.

HFE gene carrier with normal serum ferritin and normal transferrin saturation

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 [medoffeng@redcrossblood.org.au](mailto:medoffeng@redcrossblood.org.au)

APPROVED AS NORMAL BLOOD DONOR BY (THE BLOOD SERVICE STAFF)..... DATE:.....

**Privacy Statement:**

The personal information collected on this form allows the patient to be registered and enrolled as a Blood Service therapeutic or normal whole blood 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.