Coastal Bend Blood Center

209 North Padre Island Drive * Corpus Christi, TX 78406
P 361.855.4943 * F 361.855.3945

Testosterone Therapy - Request for Therapeutic Phlebotomy

Patient Information:

Full Name: Jonathan Swindle

Address: 501 Henderson Bishop, TX 78343

Date of Birth: 05 / 05 / 1989

Sex: X **Male** **Female**

Telephone #: 361-215-5089

Diagnosis: **Erythrocytosis due to Testosterone Therapy**

Frequency of Draw:

Note: If *it is not required for the patient to have blood drawn more frequent than every 8 weeks, the patient may donate as an allogeneic donor if all eligibility criteria is met and a request is not necessary.*
If the patient does not meet the criteria, then the request is required for phlebotomy.

☐ **Every two (2) weeks** ☒ **Every four (4) weeks** ☐ **Every *six (6)* weeks**

CBBC will draw one (1) unit of whole blood (approx. 500 ml), as long as the donor meets current hemoglobin requirements for allogeneic donations.

Patient must call in advance to schedule an appointment for phlebotomy.

Physician Information:

Name: Susan Linder, M.D.

Telephone #: 833-444-4483

Address: 154 W 14th St. 3-121 New York, NY, 10011

Fax #: 914-352-5999

I attest that the above patient is on **TESTOSTERONE THERAPY** and request the above patient donate blood/have a therapeutic phlebotomy performed. This person does not have any medical contraindications for this procedure.

Physician's Signature: [signature] Date: 3/15/2025

This request will be valid for one year from the date it is signed.

Altered photocopies or incomplete forms will not be accepted. Signature stamps not accepted.

* CBBC Staff: Verify donation frequency prior to draw, donor can be drawn at interval longer than prescribed frequency BUT not earlier.

Received by: _____ Date: _____ Donor #: _____