Emerson Hospital
133 Old Road to Nine Acre Corner
Concord, MA 01742
(978) 287-3360

Transfusion Services and Donor Center
(978) 287-3984 Fax - Transfusion Services
(978) 287-2918 Fax – Donor Center
emersonhosptial.org

Emerson Hospital Blood Donor Center
Physician Request Form for Hereditary Hemochromatosis

Patient_____ □ M □ F Date of Birth _____
First, Middle,Last month/day/year

Address_____ _____ _____ _____
Street city state zipcode

Phone (Home)_____ Phone (cell)_____

The above patient has been diagnosed with hereditary Hemochromatosis (HH). The patient understands that he/she will not be Charged any fee for this service, but has agreed to donate the blood drawn for transfusion purposes if he/she meets the criteria for allogeneic donation. Furthermore, he/she has agreed that I furnish the following clinical and laboratory information.

Cirrhosis: Yes___ No ___ HFE Genotype: _____ Most recent ferritin result _____ Test date_____

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 ug/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 ug/ml (which may require 2-12 phlebotomies a year).
- Pre-phlebotomy hemoglobin should remain normal because the goal of phlebotomy is to achieve low normal iron store, not iron deficiency or anemia.
- Excessively frequent phlebotomies resulting in ferritin below 50 ug/ml may increase iron absorption in patients with Hereditary Hemochromatosis and therefore not advisable.

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

*****Please draw a 450 ml unit of whole blood every _____ week(s) or _____month(s).**
*****provided that the HEMOGLOBIN result of fingerstick is greater than_____ gms/dl.**
Note: Hemoglobin will be checked by the HemoCue each visit
*****Additional Laboratory Testing orders:_____ Frequency _____**

Physician Signature: _____ Date:_____
This order must be renewed annually
Physician Name:_____
Office Address:_____
Phone:_____ Fax:_____

Signature of Blood Bank Medical Director:_____Date:_____
Fax completed form to Blood Bank Transfusion services 978-287-3984; phone 978-287-3360