THERAPEUTIC PHLEBOTOMY CONSENT FORM

I,_____ , acknowledge that my doctor has explained to me (or my authorized representative) why a Therapeutic Phlebotomy treatment of a condition explained to me as _____ is required. My doctor has explained the risks and benefits of the procedure and possible alternative treatments.

I understand that in the phlebotomy procedure one pint (or less) of blood is removed as directed by my physician.

The procedures and risks have been explained to me. I have been given the opportunity to ask questions about the procedure and about the risks, hazards, and possible complications involved. I have discussed and understood alternative methods of treatment with my physician.

I understand that there are no guarantees concerning the outcome of this procedure. All of my questions have been answered to my satisfaction.

In the event of a reaction or complication, the treating Medical Staff will provide immediate emergency medical care as indicated.

I have been informed that all information obtained in connection with this procedure, including all test results and review of my medical history and records will remain confidential to the extent provided by federal, state, and local law.

I understand that the decision to participate is voluntary. I understand that I am free to withdraw my consent and discontinue treatment at any time, verbally or in writing.

I hereby authorize that the blood cells removed from me be discarded appropriately.

SIGNATURE OF PATIENT	**SIGNATURE OF WITNESS**
	A.M. P.M.
SIGNATURE OF AUTHORIZED REPRESENTATIVE*	**DATE & TIME**

*The patient is unable to consent because: _____

_____

_____

I have personally explained the above information to the patient or patient's representative.

SIGNATURE OF PHYSICIAN	**DATE & TIME**

45-4450 Rev (03/18) CONSENT