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 Email: therapeuticphlebotomy@bloodworksnw.org

Patient Medical Condition Evaluation by Personal Health Care Provider
 (Only complete when a condition is present)

Patient's Legal Name (First, Middle, Last) _____, _____, _____
 Male Female Patient Birthdate ___/___/___ Best Contact Phone # (____) _____ cell work home

The conditions below, depending on severity, can be associated with increased risk for symptoms resulting from blood loss though blood donation (approximately 10% blood volume loss). Please check all that apply.

- Angina (Stable Unstable) Myocardial Infarction (Dates _____)
- Congestive Heart Failure Hypertrophic Cardiomyopathy/Subaortic Stenosis Restrictive Cardiomyopathy
- Heart Valve Disease: Risk for endocarditis? Yes No
- Dysrhythmia Other _____

Symptoms/Signs

- Asymptomatic Chest pain Shortness of breath Abnormal heart rate/rhythm
- Other _____

Typical frequency _____ times per Day Week Month Year Other _____

Typical duration: _____ to _____ Seconds Minutes Hours Days Other _____

Activity limitations: None ****Patient must be able to transfer to the donor bed with minimal assistance**

Able to walk _____ feet, blocks, miles on level ground

Able to climb _____ flights of stairs Symptoms at rest

To the best of my knowledge:

This patient is is not likely to be adversely affected by the loss of approximately 10% of their blood volume.

Physician Signature	Date	Physician Name (Please Print)
Physician Address	Phone	FAX

Bloodworks Physician Signature: _____ Date: _____

Draw to be performed at Central Seattle Donor Center only: Yes No