HEIRS MONTHLY QUANTITATIVE PHLEBOTOMY SUMMARY FORM

Participant ID: ☐☐-☐☐-☐☐☐☐☐-☐☐ *[affix ID label here]*

Acrostic: ☐☐☐☐☐☐

Date Form Completed: ☐☐/☐☐/☐☐ (Month / Day / Year)

Completed by: ☐☐☐

Fill out this page monthly on participants undergoing therapeutic phlebotomy treatments. Use copies of the second page repeatedly to document details of each phlebotomy treatment.

Is therapeutic phlebotomy being done at least once a month?

- ☐ No
- ☐ Yes

If therapeutic phlebotomy has not started, has stopped, or is being done less frequently than once a month, indicate the reason for stopping or low frequency:

- ☐ No visit found related to iron overload or hemochromatosis
- ☐ Clinician determined that therapeutic phlebotomy is not indicated
- ☐ Patient refused to start or continue phlebotomy (no specific reason given)
- ☐ Reached iron depletion, now on maintenance phlebotomy
- ☐ Complication or side effect (e.g., anemia)
- ☐ Illness
- ☐ Patient had, or believes she/he will have, monetary or insurance problems related to phlebotomy or iron overload
- ☐ Phlebotomy interferes with patient's work or work schedule
- ☐ Patient believes that treating her/his iron overload is not important, or that iron overload is not a serious condition
- ☐ Patient left health plan or moved (contact participant for diary follow-up)
- ☐ Patient died
- ☐ Other reason: _____
- ☐ Not known

Therapeutic Phlebotomy Form

Treatment Session

Participant ID: ☐☐-☐☐-☐☐☐☐☐☐-☐☐ *[affix ID label here]*

Acrostic: ☐☐☐☐☐☐

Date Form Completed: ☐☐/☐☐/☐☐ (Month / Day / Year)

Completed by: ☐☐☐

Phlebotomy Clinic Name: _____

Fill out one copy of this form for each phlebotomy treatment during the past month.

Therapeutic Phlebotomy Vist Number ___ of ___ this month.

1. Treatment Date ☐☐ ☐☐ ☐☐ (mo day year)

2. Was the blood weighed? yes ☐ no ☐

If yes: Weight of container only: ☐☐☐☐ grams

Weight of container and blood removed: ☐☐☐☐ grams

OR

Weight of blood removed only: ☐☐☐☐ grams

If no: Volume of blood removed: ☐☐☐ ml

OR

Number of units: ☐.☐☐ number of units

			If different from treatment date: mo	day	year
3.	Hematocrit*	☐☐.☐ %	☐☐	☐☐	☐☐
4.	Hemoglobin*	☐☐.☐ g/dl	☐☐	☐☐	☐☐
5.	Serum Ferritin	☐☐☐☐ ug/L	☐☐	☐☐	☐☐

* Done at visit or most recent within 2 weeks prior to this phlebotomy

Adverse Effects of Phlebotomy **(Check all that apply)**

6. None experienced ☐
7. Venipuncture site discomfort or bruising ☐
8. Diaphoresis ☐
9. Weakness ☐
10. Tachycardia ☐
11. Postural hypotension ☐
12. Loss of consciousness ☐

Comments: