CASCADE REGIONAL BLOOD SERVICES
YOUR COMMUNITY BLOOD CENTER

REQUEST FOR THERAPEUTIC SERVICES

ALL LINES MUST BE COMPLETE

PATIENT: _____
Last Name First Name MI

DOB: _____ PHONE #: _____

DIAGNOSIS: _____

FOR PATIENT SAFETY, DO NOT DRAW IF HgB BELOW: _____

FREQUENCY OF DRAW (e.g., "Every 2 months"): _____

_____

PHYSICIAN: _____
Please Print

PHYSICIAN PHONE #: _____ FAX #: _____

_____ _____
Physician's Signature Date

FAX TO: 253-572-6340 or EMAIL TO: ATMD@CRBS.NET
PHONE (253) 383-2553

Tacoma	**Puyallup**	**Federal Way**
220 South I Street	615 E Pioneer, Suite 114	909 South 336th St #B-102
Tacoma, WA 98405	Puyallup, WA 98371	Federal Way, WA 98003

CRBS use only: CRBS Staff Initials/Date: _____

❑ Verbal Order given by: _____
Name/Title

COPY ON 2-PART NCR