



**CASCADE REGIONAL
BLOOD SERVICES**
YOUR COMMUNITY BLOOD CENTER

REQUEST FOR THERAPEUTIC SERVICES

PATIENT: _____
Last Name First Name MI

DOB: _____ PHONE #: _____

DIAGNOSIS: _____

DO NOT DRAW IF HCT/HgB BELOW: _____

FREQUENCY: _____

PHYSICIAN: _____
Please Print

PHYSICIAN PHONE #: _____ FAX #: _____

Physician's Signature Date

FAX TO: 253-572-6340
PHONE (253) 383-2553

Tacoma
220 South I Street
Tacoma, WA 98405

Puyallup
615 E Pioneer, Suite 114
Puyallup, WA 98371

Federal Way
909 South 336th St #B-102
Federal Way, WA 98003

CRBS use only: CRBS Staff Initials/Date: _____

Verbal Order given by: _____
Name/Title