Irish Blood Transfusion Service
Seirbhís Fuilaistriúcháin na hÉireann

PLEASE BRING THIS PRESCRIPTION

EACH TIME YOU ATTEND THE CLINIC

Patient's Name:	Date of Birth:
Address:	

Phlebotomy of 470 mls

Repeat x 3, with intervals of not less than 90 days between any 2 phlebotomies.

I certify - Patient Name_____

That the above named patient has been diagnosed with hereditary haemochromatosis.

That this patient is being prescribed these venesections in accordance with the Guidelines of the Irish College of General Practitioners (Nicholson A Hereditary Haemochromatosis: diagnosis & management from a GP perspective, ICGP 2009)

That the patient's Serum Ferritin concentration ¡s <600 ug/L

I acknowledge that, other than for care pertaining to the venesection process itself, responsibility for the further care of this patient's haemochromatosis remains with myself.

Doctor's Name and Address/Name & Hospital of referring Consultant:

Signature of Doctor or Clinical Nurse Specialist (Hospital Haemochromatosis Clinic):

Signature: _____ Medical Council Reg. No. _____

IBTS Use Only :Phlebotomy Record

Date	Volume	Remarks	Name and Signature of Phlebotomist
1.			
2.			
3.			
4.			

Clinics by appointment only (DUBLIN clinic 01474 5000 & CORK clinic 021-4807400)
For further information on the IBTS Haemochromatosis clinics visit w.vw.giveblood.ie
BT — 0588 Version 4 May 2016