Bloodless Center Consult
Office Number: (860) 972-2791
Fax Number: (860) 545-2309

Address:
Bloodless Center
85 Seymour Street, Ste. 601
Hartford, CT 06106

Available Days:
Select Fridays 8:00 AM-12:00 PM

Patient Name: ______________________________ MR #: ________________________

Date of Birth:____________________ Phone Number: ______________________________

Reason for Referral: ☐ Jehovah Witness

☐ Other : ____

____

Pregnancy EDD/Procedure:____

Past Surgeries: ____

Referred By: ____

Phone Number: _____________________ **Fax Number: __________________________

Additional comments: ____

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***Please attach recent CBC results with referral if available**

****Please provide fax number where you want signed consents and consultation report to be sent.**

Form completed by: _______________________________

Phone Number: _______________________________

Date Faxed: _______________________________

Bloodless Center confirmation: Appointment Date/Time: ____________________

Completed Consents faxed to Referring OB/Practice Date: ____________________