

THERAPEUTIC PHLEBOTOMY ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI _____ DOB: _____

HT: _____ in WT: _____ kg Sex : Male Female Allergies: NKDA, _____

Physician Name _____ Contact Name _____ Contact Phone # _____

NPI #: _____ Tax ID#: _____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD 10 CODE + DESCRIPTION)

Secondary Diagnosis: (ICD 10 CODE + DESCRIPTION)

PRESCRIPTION ORDERS

- a) ALL MEDIPOINTS / IV ACCESSES WILL BE FLUSHED WITH HEPARIN OR SALINE PER HOSPITAL POLICY PRN
- b) 10 mL NS Flush Syringe PRN
- c) ORDERS WITH INCOMPLETE PARAMETERS WILL DELAY PATIENT CARE AND WILL NEED TO BE CORRECTED BY PROVIDER

TREATMENT	mL TO REMOVE (+/- 50 mL)	PARAMATERS	FREQUENCY	DURATION
Therapeutic Phlebotomy		HOLD if ≤ _____	<input type="checkbox"/> 1 x only <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other:	

LABS			NOTES/INSTRUCTIONS/OTHER
SELECT	LAB REQUESTED	FREQUENCY	
<input type="checkbox"/>	NONE	NA	
<input type="checkbox"/>	CBC w/ Diff	PRIOR TO EACH PHLEBOTOMY	
<input type="checkbox"/>	Hgb	PRIOR TO EACH PHLEBOTOMY	
<input type="checkbox"/>	Hct	PRIOR TO EACH PHLEBOTOMY	
<input type="checkbox"/>	BMP		
<input type="checkbox"/>	CMP		
<input type="checkbox"/>	BUN/CREATININE		
<input type="checkbox"/>	ESR		
<input type="checkbox"/>	CRP		
<input type="checkbox"/>	CPK		
<input type="checkbox"/>	Ferritin		
<input type="checkbox"/>	Other:		
<input type="checkbox"/>	Other:		

Physician's Signature _____ Time _____ Date _____
*Signature Must Be Clear and Legible

Cosignature (If Required) _____ Time _____ Date _____
*Signature Must Be Clear and Legible

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.