Endeavor Health

THERAPEUTIC PHLEBOTOMY ORDER FORM

Patient Name:_____ DOB:_____

PLEASE ATTACH A COPY OF INSURANCE CARD WITH THIS ORDER

Diagnosis:_____ICD-9:_____

THERAPEUTIC PHLEBOMOTY INSTRUCTIONS

LAB ORDERS:_____

- ☐ **CBC**
- ☐ **Ferritin**
- ☐ **HCT**

Amount: One Unit(500 ml):_____ Less than one unit(Specify amount):_____

Frequency: One time Only_____ Weekly_____ Monthly_____ Other(Specify)_____

Duration of Treatment: _____

Note: Recurrent therapeutic phlebotomy orders must be updated on an annual basis.

Collection Instructions regarding minimum Hgb (Check One):
_____ Do not perform therapeutic phlebotomy if Hgb is less than 11 gm/dl
_____ Do not perform therapeutic phlebotomy if Hgb is less than (specify)_____ gml/dl
NOTE: Minimum Hemoglobin of less than 11gm requires approval of the Blood Bank medical director
NOTE: High risk conditions require prior approval of the Blood Bank Medical Director: MI (past year), aortic / sub aortic stenosis, unstable angina, asthma, emphysema, COPD, Oxygen therapy, CVA/Stroke/TIA (past year), seizures (past year), physically / mentally challenged, weight<110 pounds, communication barrier, or other high-risk condition.

Special Instructions/ Precautions (e.g., Fluid replacement):_____

_____

_____ _____

Physician Signature Date

_____ _____ _____

Physician Name(Please Print) Office Phone Fax Number