Community HOSPITAL

THERAPEUTIC PHLEBOTOMY ORDER FORM

PATIENT NAME:	OFFICE PHONE #:
PATIENT PHONE #:	OFFICE FAX #:
ORDERING PROVIDER:	PATIENT DOB:
NURSE/MA:	PRIOR AUTH OBTAINED: ☐Yes ☐No
PATIENT ALLERGIES:	PRIOR AUTH #: (*required*)
DIAGNOSIS/ICD-10 CODE: (required)	FIRST TIME THERAPEUTIC PHLEBOTOMY? ☐Yes ☐No

VOLUME OF WHOLE BLOOD TO BE REMOVED: _____ mls	FREQUENCY OF THERAPEUTIC PHLEBOTOMY: ☐ once ☐ once every _____ ☐days ☐weeks ☐months

HYDRATION:

☐ none

☐ give _____ mls 0.9% Sodium Chloride IV infusion following Therapeutic Phlebotomy

PERFORM THERAPEUTIC PHLEBOTOMY WHEN:

☐ Hct >_____

☐ Ferritin >_____

☐ Other: _____ ☐ No parameters required

PERTINENT PATIENT INFORMATION/DIAGNOSES:

☑ I authorize use of the Community Hospital Adult Hypersensitivity Reaction/Anaphylaxis Protocol

Provider's Signature: _____ Date: _____

order expires one year from written date

form updated 06/09/2020