SOMC Cancer Center & Infusion
Ph: (740) 356-7490
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Therapeutic Phlebotomy Order Form

PATIENT & PRESCRIBER INFORMATION

Patient Name: _____ DOB: _____ Phone: (H) _____ (C) _____

Patient Address: _____

Ht.: _____ Wt.: _____ ☐lbs. ☐kg. Allergies: _____

Prescriber Name/Title: _____ Address: _____

Phone: _____ Fax: _____ Prescriber NPI #: _____

REQUIRED: **Most Recent H&P, clinical notes, & medication list are required unless the patient is established with SOMC. Supporting clinical notes should include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

LAB RESULTS: Hemoglobin, Hematocrit, and/or Ferritin (if indicated) within 30 days

DIAGNOSIS, CLINICAL INFORMATION, & PRESCRIPTION

☒ **Monitor for any adverse events post procedure for at least 30 minutes or until clinically stable.**

(Check all that apply)

Diagnosis

- ☐ Polycythemia Primary Vera
- ☐ Polycythemia due to Testosterone Therapy
- ☐ Hemochromatosis Hereditary
- ☐ Hemochromatosis Non-Hereditary

Lab Orders ☐ Pre Infusion ☐ Post Infusion

- ☐ Hemoglobin
- ☐ Hematocrit
- ☐ CBC
- ☐ CBC with Diff
- ☐ Ferritin

Parameters

Remove if Hgb is greater than _____g/dl Hematocrit greater than _____%

- ☐ Other _____

Volume

- ☐ Remove 500 ml (530 g)
- ☐ Normal Saline 500 ml IV for hydration post phlebotomy over 30 min
- ☐ Remove 250 ml (265 g)
- ☐ Normal Saline 250 ml IV for hydration post phlebotomy over 30 min
- ☐ Other _____

Frequency

- ☐ Weekly
- ☐ Every _____ weeks
- ☐ Monthy
- ☐ Other _____

PROVIDER:	DATE:	TIME:	SIGNATURE: