



THERAPEUTIC PHLEBOTOMY ORDER FORM

Provider Instructions:

**** INCLUDE WITH ORDER: CBC or H and H (each order) and Ferritin (if not done within last 6 months) ****

Please complete all fields to avoid delays

PLEASE FAX COMPLETE FORM TO: 406-414-1841

ALLOW AT LEAST TWO BUSINESS DAYS FROM ORDER FORM SUBMISSION FOR PROCESSING

Patient Information

Last Name:	First Name:	Middle Name:
Street Address:		DOB:
City:	State:	Zip:
Does the patient have a medical condition that may increase the risk of adverse reaction and require medical supervision during Phlebotomy? <input type="checkbox"/> No <input type="checkbox"/> Yes, please explain: _____		
Indication for phlebotomy: <input type="checkbox"/> D75.1 Polycythemia or Erythrocytosis, secondary <input type="checkbox"/> R79.89 Other Abnormal Blood Chemistry <input type="checkbox"/> E83.110 Hereditary Hemochromatosis <input type="checkbox"/> D45 Polycythemia Vera (Primary) <input type="checkbox"/> D75.0 Familial Polycythemia or Erythrocytosis <input type="checkbox"/> Other: _____		

Type of Phlebotomy

<input type="checkbox"/> 500 ml	<input type="checkbox"/> 250 ml	<input type="checkbox"/> Other, please explain _____
---------------------------------	---------------------------------	--

Order Details

Frequency and Duration of Phlebotomy: <input type="checkbox"/> One Time Only <input type="checkbox"/> Weekly <input type="checkbox"/> Every _____ weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Other, specify: _____	
Additional orders: please specify if this will be a standing order and time period <input type="checkbox"/> CBC <input type="checkbox"/> H and H <input type="checkbox"/> Ferritin <input type="checkbox"/> Standing order _____ Time period	
Additional Instructions: Total number of Phlebotomies _____ Number of Months order is valid (maximum 12 months) _____	
Do not perform phlebotomy if: (all cutoff values MUST be included) Hemoglobin is less than: _____ Hematocrit is less than: _____ Ferritin is less than: _____	

Ordering Provider Information

Provider Signature _____	Provider Name _____
Date _____	Office Address _____
Phone number _____	Fax Number _____

Note: This Form is associated with the following document:	Therapeutic Phlebotomy Procedure	Page 1 of 1
Note: When completed this Form will be retained:	Therapeutic Phlebotomy Folder	