3-Hole 1/4 1 3/8 c-to-c

THERAPEUTIC PHLEBOTOMY ORDER SHEET

Orders Provider

PLEASE FILL THIS FORM OUT COMPLETELY

ONLY COMPLETED, CIRCLED, OR CHECKED ORDERS WILL BE ACTIVATED

CBC ASAP is done routinely with each phlebotomy.
Any volume greater than 450 ml will be replaced with an equivalent volume of NSS, unless ordered otherwise.

1(a). **Phlebotomy for POLYCYTHEMIA**
Current CBC results (within a week) are required prior to phlebotomy.

❑ Remove (please circle) ___1___2__ unit(s) (approx. 450 ml/unit) **NOW (1st time order only)**
AND THEN
❑ Remove 1 unit q _____ (please circle) week(s) / month(s) if hematocrit is greater than _____%.

1(b). **Phlebotomy for HEMOCHROMATOSIS**
Ferritin from the LAST phlebotomy will be used (if done within 90 days), unless ordered otherwise.
A Ferritin level will be done **after** every 4th unit removed unless another other interval is ordered below.

❑ Remove (please circle) ___1___2__ unit(s) (approx. 450 ml/unit) **NOW (1st time order only)**
AND THEN
❑ Remove 1 unit q _____ (please circle) **week(s) / month(s)** as long as previous hematocrit is greater than _____% **AND** last ferritin is above _____mg/ml.

1(c). **Phlebotomy for OTHER:**
Diagnosis:_____
Instructions & Frequency: _____
_____

2. **Additional Laboratory Tests Requested**
❑ _____
❑ _____

3. **Fluid Replacement (check one)**
❑ 250 ml / 500 ml (please circle) Normal Saline replacement for each unit removed
❑ Normal Saline PRN fluid replacement if patient becomes lightheaded, dizzy or has decreased LOC

4. **Other Instructions**
❑ Special testing:_____
❑ Fluid limitations: _____
❑ Other health problems:_____

Signature: _____
Printed Name/ID#: _____
Date: _____ Time: _____

Order Reviewed and Approved
PInC Medical Director Signature: _____ **Date:**_____ **Time:** _____

Renewals or changes:

_____ Signature: _____ Date: _____ Time: _____
_____ Signature: _____ Date: _____ Time: _____

PATIENT IDENTIFICATION

PRESBYTERIAN
Infusion Center / Apheresis Services
Tele: (505) 563-1309
Fax: (505) 224-7156

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