

Outpatient Infusion Center

Fax: 405-307-2244 Phone: 405-515-2470



Therapeutic Phlebotomy

1 (1)	erapeutic Phiebotom	У
Patient and Physician Informati	on	
Patient Name:	Date of Birth:	Patient Phone Number:
Physician Name:	Office Phone Number:	Fax Number:
Insurance:	Group Number:	Policy Number:
Hospitalization Status:	Patient Weight (kg):	Height (inches):
☑ Outpatient to Outpatient Infusion Center		
Allergies:		
Send patient demographics	(incurance clinical notes on	d toot recults with and re
Send patient demographics	misurance, chinical notes, and	u test results with orders
Diagnosis Code/Description for treatme	nt:	
Orders		
	AN as FOLIAL to	and a sittle the annual sittle and labeled the second of LINITE
☐ Hemogram – If Hemoglobin is GREATER TH Repeat EVERY week(s) until Hemoglo		
Repeat EVERT Week(3) until Hemogro	5111 13g, dE 101 2 consect	ative treatments, then discontinue order.
\square Hemogram – If Hematocrit is GREATER THA	AN or EQUAL to%, proc	eed with therapeutic phlebotomy, 1 UNIT.
Repeat EVERY week(s) until Hematoc	rit is% for 2 consecutive	treatments, then discontinue order.
☐ Ferritin – If Ferritin is GREATER THAN or E	OUAL to na/ml proceed	with theraneutic phlehotomy 1 UNIT
Repeat EVERY week(s) until Ferritin i		
Other:		
Discharge ☑ Discharge home after treatr	ment complete if stable.	
Date and Physician Signature		
DATE: TIME:		PHYSICIAN'S SIGNATURE
10872508	Page 1 of 1	