NORMAN REGIONAL Health System

Outpatient Infusion Center

Fax: 405-515-5089
Phone: 405-515-2470

ORD

Therapeutic Phlebotomy

Patient and Physician Information

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/insurance, clinical notes, and test results with orders*****

Diagnosis Code/Description for treatment: _____

Orders

☐ Hemogram – If Hemoglobin is GREATER THAN or EQUAL to _____g/dL, proceed with therapeutic phlebotomy, 1 UNIT. Repeat EVERY _____ week(s) until Hemoglobin is _____g/dL for 2 consecutive treatments, then discontinue order.

☐ Hemogram – If Hematocrit is GREATER THAN or EQUAL to _____%, proceed with therapeutic phlebotomy, 1 UNIT. Repeat EVERY _____ week(s) until Hematocrit is _____% for 2 consecutive treatments, then discontinue order.

☐ Ferritin – If Ferritin is GREATER THAN or EQUAL to _____ng/mL, proceed with therapeutic phlebotomy, 1 UNIT. Repeat EVERY _____ week(s) until Ferritin is _____ng/mL for 2 consecutive treatments, then discontinue order.

Other:_____

Discharge ☑ Discharge home after treatment complete if stable.

Date and Physician Signature

DATE:_____ **TIME:**_____

_____
PHYSICIAN'S SIGNATURE

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DO NOT WRITE ON OR BELOW THIS AREA ORDERS MAY BE CUT OFF BY FAX MACHINES