EDWARD
CANCER CENTERS

120 Spalding Drive; Suite 111; Naperville, IL 60540
Phone: 630/527-3788 Fax: 630/548-6617

THERAPEUTIC PHLEBOTOMY ORDER FORM

Patient Name: _____ DOB: _____

PLEASE ATTACH COPY OF INSURANCE CARD WITH THIS ORDER

If you have any questions regarding pre-authorizations, please contact Katie Jones at (630) 646-6168 or kajones@edward.org.

Diagnosis: _____ ICD-9: _____

THERAPEUTIC PHLEBOTOMY INSTRUCTIONS

Lab Orders: _____

☐ **Peripheral** ☐ **Fingerstick (Hgb only)**
- ☐ **CBC**
- ☐ **Ferritin**
- ☐ **Hct**

Amount: One Unit (500 ml): _____ Less than one unit (specify amount): _____

Frequency: One time only ____ Weekly ____ Monthly ____ Other (specify): _____

Duration of Treatment: _____

Note: Recurrent therapeutic phlebotomy orders must be updated on an annual basis.

Collection Instructions regarding Minimum Hgb (check one):

_____ Do not perform therapeutic phlebotomy if Hgb is less than 11 gm/dl

_____ Do not perform therapeutic phlebotomy if Hgb is less than (specify): _____ gml/dl

Note: Minimum hemoglobin of less than 11gm requires approval of the Blood Bank Medical Director.

NOTE: High risk conditions require prior approval of the Blood Bank Medical Director: MI (past year), aortic / sub aortic stenosis, unstable angina, asthma, emphysema, COPD, Oxygen therapy, CVA/Stroke/TIA (past year), seizures (past year), physically / mentally challenged, weight <110 pounds, communication barrier, or other high risk condition.

Special Instructions/Precautions (e.g., fluid replacement): _____

_____

_____ _____
Physician Signature **Date**

_____ _____ _____
Physician Name (Please Print) **Office Phone** **Fax Number**

Revision/Review Date: 01.29/15