



Legal Patient Name:	DOB:
ICD 10 Diagnosis Code:	Diagnosis: <input type="checkbox"/> Polycythemia <input type="checkbox"/> Polycythemia Vera <input type="checkbox"/> Hemochromatosis <input type="checkbox"/> Hereditary Hemochromatosis <input type="checkbox"/> Other _____

THERAPEUTIC PHLEBOTOMY ORDERS

Parameters

- Remove _____ mL of blood
- Select applicable parameter below:
 - HOLD if hemoglobin is below _____
 - HOLD if hematocrit is below _____
 - HOLD if ferritin is below _____
 - Other _____

Frequency & Duration

* Must be a defined timeframe "as needed" is not acceptable.

- One time
- Weekly for a total of _____ procedures
- Every _____ weeks for a total of _____ procedures
- Other _____

Labs

Date of most recent lab result _____

*MUST include copy of most recent lab results (unless results are found in EPIC)

*Ordering provider is responsible for monitoring labs throughout the duration of this order

*UM Health-Sparrow Infusion Center will only VERIFY that patient meets parameters for therapeutic phlebotomy

Printed Provider Name: _____ Office Phone: _____

Provider Signature: _____ Date: _____ Time: _____