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Suite 101
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# Therapeutic Phlebotomy Order Form

Epic Referral: REF115222

**Patient Name:** ________________________________________ **DOB:** _________________________

**Address:** ____________________________________________________________________________

**Phone:** _____________________________________ **ICD-10 Diagnosis:** ______________________

**Rx:**

Draw Hemoglobin and Hematocrit at each therapeutic phlebotomy visit.

Remove ___________________ of blood:
(volume of blood in mL)

Frequency: ☐ Once ☐ Weekly ☐ Every 2 weeks ☐ Every 4 weeks ☐ Other frequency: __________

Do not perform if Hemoglobin < _____________ or Hematocrit < ______________

Order good for: ☐ 3 months ☐ 6 months ☐ 1 year ☐ Other: _________________________

Any additional orders/comments:

______________________________________________________________________________________

______________________________________________________________________________________

**Prescriber Printed Name:** ____________________________________________________________

**Prescriber Full Address:** ____________________________________________________________

**Office Phone Number:** _______________________ **Office Fax Number:** ______________________

**Prescriber Signature:** ________________________________________ **Date:** ___________________