

**SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
 THERAPEUTIC PHLEBOTOMY ORDER FORM**

STAT REFERRAL

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI _____ DOB: _____
 HT: _____ in WT: _____ kg Sex: () Male () Female Allergies: () NKDA, _____

Physician Name _____ Contact Name _____ Contact Phone # _____
 NPI #: _____ Tax ID#: _____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD 10 CODE + DESCRIPTION) _____ Secondary Diagnosis: (ICD 10 CODE + DESCRIPTION) _____

PRESCRIPTION ORDERS

- a) ALL MEDIPOINTS / IV ACCESSES WILL BE FLUSHED WITH HEPARIN OR SALINE PER HOSPITAL PROTOCOL PRN
- b) 10ml NS Flush Syringe PRN
- c) ORDERS WITH INCOMPLETE PARAMETERS WILL NOT BE SERVICED

	MLS TO REMOVE (+/- 50MLS)	PARAMATERS	FREQUENCY	DURATION
Therapeutic Phlebotomy		HOLD if ≤	<input type="checkbox"/> 1 x only <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other:	

LABS			NOTES/INSTRUCTIONS/OTHER
SELECT BELOW	LAB REQUESTED	FREQUENCY	
	NONE	NA	
	CBC w/ Diff	PRIOR TO EACH PHLEBOTOMY	
	Hgb	PRIOR TO EACH PHLEBOTOMY	
	Hct	PRIOR TO EACH PHLEBOTOMY	
	BMP		
	CMP		
	BUN/CREATININE		
	ESR		
	CRP		
	CPK		
	Ferritin		
	Other:		
	Other:		

Physician's Signature _____ Time _____ Date _____
**Signature Must Be Clear and Legible*

Cosignature (If Required) _____ Time _____ Date _____
**Signature Must Be Clear and Legible*

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.