Southwestern Medical Center
Empowered by ScionHealth
Phone: 580-531-4892
Fax: 877-249-1191

☐ **STAT REFERRAL**

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
THERAPEUTIC PHLEBOTOMY ORDER FORM

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 MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH HEPARIN OR SALINE PER HOSPITAL POLICY PRN
b) 10 mL NS Flush Syringe PRN
c) ORDERS WITH INCOMPLETE PARAMETERS WILL NOT BE SERVICED

TREATMENT	mL TO REMOVE (+/- 50 mL)	PARAMATERS	FREQUENCY	DURATION
Therapeutic Phlebotomy		HOLD if ≤_____	☐ 1 x only ☐ Weekly ☐ Monthly ☐ Other:	

LABS

SELECT	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:	

NOTES/INSTRUCTIONS/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.