Therapeutic Phlebotomy Prescription

uchealth

Patient Name: _____ **Date of Birth:** _____
Last First MI

❑	**Hemochromatosis**	❑ E83.118 ❑ E83.119 ❑ E83.110 ❑ E83.10 ❑ E83.19 ❑ R79.89 ❑ E83.111	
❑	**Secondary Polycythemia related to Testosterone Therapy**	❑ E29.1 ❑ D75.1	*Note: only enter E29.1 in EPIC
❑	**Secondary Polycythemia (NOT related to Testosterone Therapy)**	❑ D75.1	
❑	**Primary Polycythemia Vera (PCV, other rare genetic polycythemias)**	❑ D45 ❑ D75.0	
❑	**Porphyria**	❑ E80.0 ❑ E80.20 ❑ E80.29	
❑	**Other (specify):**	ICD10 Code (required): ❑	Describe (required):

Frequency of Draw (Required):

❑ One time only ❑ Weekly ❑ Monthly ❑ Other: _____ (If not specified, default is 56 days)

Minimum Hemoglobin (Required):
Do not permit phlebotomy if Hemoglobin is less than _____ g/dL (Default if not specified will be 13g/dL)

Note: A hemoglobin test will be performed before the procedure to evaluate eligibility as defined by this order. A hemoglobin performed by any UCHealth Laboratory within the past 7 days may be substituted. For purposes of this facility, if a minimum hematocrit is provided instead of hemoglobin, we will divide the hematocrit by three (3) to determine the minimum hemoglobin.

Volume to be collected (Required):

❑ **One unit of Whole Blood (450-500 mL)** ❑ **Other (specify):** _____

❑ **Two Red Cell units by apheresis collection, only if the donor qualifies** as determined by the donor's height/ weight/hematocrit. A double Red Cell procedure is not an option if the donor's hemoglobin is or exceeds 18.3 g/dL. If donor does not qualify for the automated procedure, one unit of Whole Blood will be collected.

Ordering Provider Information (Required):

Provider Printed Name: _____

Phone Number: _____ Fax Number: _____

I have evaluated this patient and I am aware of no contraindications to this procedure. I have explained the reason for this procedure to the patient, including the fact that a fee may be charged directly to the patient by the blood center. I will be responsible for the patient's follow-up care.

With my signature, I am confirming and verifying the diagnosis listed above.

Signature: _____ **Date**: _____

This order is valid for one year from the date the order is signed by the provider unless otherwise specified

For Donor Center Staff Use only

☐ Not a new therapeutic patient / Medical Director approval is N/A _____(initial) Date: _____

☐ Blood Bank Medical Director verbal approval obtained by: _____ Date: _____

Entered into EPIC by: _____ Date: _____

Blood Bank Medical Director approval: _____ Date: _____

UCHealth Garth Englund Blood Center, Laboratory Services

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