Therapeutic Phlebotomy Prescription

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 or hematocrit 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 and no recent laboratory result is available, we will divide the hematocrit by three (3) to determine the minimum hemoglobin.

Volume to be collected: (Default if not specified will be one unit)

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

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: _____

☐ Entered into EPIC by: _____ Date: _____

GEBC Medical Director approval/date: L T

UCHealth Garth Englund Blood Center, Laboratory Services

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F: 970.482.0782

Loveland Location (at MCR)
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Loveland, CO 80538

O: 970.624.1510
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Greeley Location
6906 W 10th Street
Greeley, CO 80634

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