Salem Health®
Hospitals & Clinics

Therapeutic Phlebotomy Order Form

(**All** information requested is **required**)

This is the patient's 1st Therapeutic Phlebotomy: **YES** or **NO** (choose one)

Patient's Full Name: _____

Patient's Date of Birth: _____

Ordering Provider: _____

Order Date: _____

Frequency (e.g. once; monthly): _____

Diagnosis Code(s): _____

Volume (e.g. no more than 1 unit=450ml drawn per 24 hours): _____

Hold if: _____

Required pre labs:

☒ H&H (required for all therapeutic orders)
☐ Ferritin (required for Dx: Hemochromatosis)

Pre Labs are to be completed no more than 2 weeks prior to the therapeutic phlebotomy

***If pre labs have been completed, attach results to this order form.

☒ Okay for patient to receive lab results.

Provider's Signature: _____

For Lab Use only

MRN: