uchealth

Therapeutic Phlebotomy Order

Yampa Valley Medical Center
Laboratory

1024 Central Park Drive
Steamboat Springs, CO 80487

O 970.871.2350
F 970.871.2573

Patient name ______________________________

Gender: ☐ Male ☐ Female Date of Birth ______________________________

Address ______________________________

Phone ______________________________ Date of order (update every 12 months) ______________________________

Diagnosis

☐ Hereditary Hemochromatosis (E83.110) ☐ Non-hereditary Hemochromatosis (E83.118)

☐ Polycythemia, Primary (D45) ☐ Polycythemia, Secondary (D75.1) ☐ Porphyria Cutanea Tarda (E80.1)

☐ Other ______________________________

List any medical conditions that we should be made aware of ______________________________

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Note: Other conditions may require additional information and MD approval.

Volume of Phlebotomy

☐ Whole Blood (500 mL) ☐ Whole Blood 1/2 unit (250 mL)

☐ Other ______________________________

Frequency and Duration of Phlebotomy

☐ One time only ☐ Weekly ☐ Every __________ weeks ☐ Monthly ☐ Other ______________________________

Additional instructions, if indicated

Total number of procedures ______________ End date of prescription (max. 12 months) ______________

Minimum Hemoglobin and Additional Testing

Do not permit phlebotomy if hematocrit is below ______________.

- 33.0 is the minimum permitted without prior Pathology approval.)
- **Default will be 37.5 (female) or 39.0 (male) whole blood, if not specified.**

Additional testing to draw and frequency ______________________________

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Name of ordering provider ______________________________

Signature of ordering provider ______________________________ Date/Time ______________

Address ______________________________

Phone ______________________________ FAX ______________________________