Therapeutic Phlebotomy Prescription

uchealth

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

✓	Diagnosis:	ICD10 Code (Required):	
❑	**Hemochromatosis**		
❑	**Secondary Polycythemia related to Testosterone Therapy**		
❑	**Secondary Polycythemia (NOT related to Testosterone Therapy)**		Due to (required)
❑	**Primary Polycythemia Vera (PCV, other rare genetic polycythemias)**		
❑	**Other (specify)**		Describe (required):

Frequency of Draw (Required):

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

Minimum Hematocrit (Required):

Do not permit phlebotomy if Hematocrit is less than _____ % (Default if not specified will be 38%)

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

✓ **Volume to be collected (Required):**

❑ **One unit of Whole Blood** ❑ **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 hematocrit is or exceeds 55%. 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 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

Fort Collins Location
1025 Pennock Place, Suite104
Fort Collins, CO 80524

O: 970.495.8965
F: 970.495.8967

Loveland Location (at MCR)
2500 Rocky Mountain Avenue
Loveland, CO 80538

O: 970.624.1510
F: 970.624-1591

Place Patient Identification Label Here