ArrIVe
INFUSION THERAPY

Phlebotomy Order Form

Name: _____
Date of Birth: _____

Diagnosis Code (ICD-10) and Indication: _____

Procedure Name: Phlebotomy

Lab orders (within 45 days): (physician to provide patient with laboratory requisition)
Prior to each phlebotomy: CBC
Monthly, or prior to each phlebotomy (whichever is greater interval): Ferritin, Iron % Saturation.
Other: _____
Hold parameter: Hold phlebotomy for Hemoglobin below 13 (men) 12 (women) (hemochromatosis), Hematocrit equal/below 45% (men) 42% (women) (polycythemia vera) OR Ferritin below 50 ng/mL

Other hold parameter(s): _____

Orders (please select):
□ Phlebotomize 1 unit (500 mls)
□ Phlebotomize 1/2 unit (250 mls)

Frequency: every ___( ) week(s) every month _____
Duration: for _____ months (not valid for more than 1 year from date of signature).
Hydration orders: Infuse 500-1000 ml NS prn for hypotension.
Discharge patient when stable.

Other orders:

Physician Signature: _____ **Date:** _____

Physician Name (Printed): _____ **Office Contact:** _____

Note: this order is valid for 12 months from date of physician signature.