GREY BRUCE Health SERVICES

THERAPEUTIC PHLEBOTOMY ORDER FORM

Drug Allergies: _____

_____

_____

Page #____ _____

Date: Time:

Patient's name: _____

DOB (mm/dd/yyyy): _____ Health Card Number: _____

Address: _____

_____

Phone number: (_____) _____

Diagnosis: _____

Initials	Kardex	Lab Work		
		❑ CBC	Frequency:	Cutoff:
		❑ CBC with Diff	Frequency:	Cutoff:
		❑ Ferritin level	Frequency:	
		❑ Iron profile	Frequency:	
		Therapeutic Phlebotomy Instructions		
		Amount:		
		❑ one unit (500) mL		
		❑ less than one unit (specify amount):		
		Frequency:		
		❑ one time only ❑ weekly ❑ monthly		
		❑ Other (specify):		

Post Procedure instructions/precautions: _____

This order is valid for one year.

*Please √ if your patient has **any of the following conditions**.*

Pre-existing conditions:	**Other:**
❑ MI within last month	❑ CVA / Stroke / TIA within last 6 months
❑ Aortic / Subaortic stenosis	❑ Seizures within last 6 months
❑ Unstable angina	❑ Physically / mentally challenged
❑ Asthma / Emphysema / COPD	❑ Weight < 82 lbs / 37 kg
❑ O_2 therapy required	❑ Communication barrier
❑ Other (specify):	❑ Other (specify):

MD signature: MD Name (Please print)