Center for Infusion Care
HILLSDALE HOSPITAL
Phone: (517) 212-4336 | **Fax:** (877) 249-1191
hillsdalehospital.com/infusion

☐ **STAT REFERRAL**

THERAPEUTIC PHLEBOTOMY ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ in WT: _____ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA, _____

_____

Physician Name_____ Contact Name _____ Contact Phone # _____

NPI #:_____ Tax ID#:_____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD 10 CODE + DESCRIPTION)

_____

Secondary Diagnosis: (ICD 10 CODE + DESCRIPTION)

_____

PRESCRIPTION ORDERS

a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH HEPARIN OR SALINE PER HOSPITAL PROTOCOL PRN
b) 10ml NS Flush Syringe PRN

	MLS TO REMOVE +/- 50MLS	PARAMATERS	FREQUENCY	DURATION
Therapeutic Phlebotomy		**HOLD IF** **if ≤**	☐ **1 x only** ☐ **Weekly** ☐ **Monthly** ☐ **Other:**	

LABS

SELECT BELOW	LAB REQUESTED	FREQUENCY
	NONE	**NA**
	CBC w/ Diff	**PRIOR TO EACH PHLEBOTOMY**
	Hgb	**PRIOR TO EACH PHLEBOTOMY**
	Hct	**PRIOR TO EACH PHLEBOTOMY**
	BMP	
	CMP	
	BUN/CREATININE	
	ESR	
	CRP	
	CPK	
	Ferritin	
	Other:	
	Other:	

NOTES/INSTRUCTIONS/OTHER

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Physician's Signature _____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

Cosignature (If Required)_____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.