



Therapeutic Phlebotomy Order

Date: _____ For appointments or questions call (_____) _____

Patient Name _____

Last

First

Middle

Patient Address (Street, City, State, Zip) _____

Patient's Phone Number: _____

Gender: Male Female

Date of Birth: _____

Therapeutic Phlebotomy Orders

Volume: One unit whole blood* Double red blood cells (~400 mL red cells)

Less than one unit* (specify volume) _____

Frequency: One time only Once every _____ week(s)

Once every _____ Month(s) Other (specify) _____

Duration: Number of Total Procedures _____

Number of months prescription is valid (Maximum 12 months) _____

Lower Level

of Maintenance Do not draw patient if hemoglobin is less than _____ g/dl

- Hgb values for whole blood collection < 11 g/dl require UBS physician approval.
- Hgb values for double red blood cell collection < 12 g/dl require UBS physician approval.
- **Default Minimum:** 12.5 g/dl for whole blood or 13.3 g/dl for double red blood cells is used, If not specified. These values may not be appropriate for your patient.

*** BSI criteria: 500 mL ± 10% may be collected depending on patient's total blood volume (TBV). Target collection volume should not exceed 15% of patient's TBV. Smaller patients may not qualify for a full whole blood unit collection.**

Medical History

Diagnosis

- Hereditary Hemochromatosis Non-hereditary Hemochromatosis Porphyria Cutanea Tarda
 Polycythemia, Primary Polycythemia, Secondary Other _____

Note: Other conditions may require additional information and UBS Physician approval.

Please check if the patient has any of the following medical conditions:

- MI w/in last 6 months COPD, Asthma, Emphysema Aortic/subaortic stenosis
 Unstable angina CVA/Stroke/TIA w/in last 6 months Seizures w/in last 3 months
 Other (specify) _____

Special Instructions / Additional Orders _____

Ordering Physician Information

Physician Signature _____ Physician Name _____

Office Phone # (_____) _____ Office Fax # (_____) _____

Office Address _____

UBS Use Only

Request Evaluated: Approved, Meets SOP criteria Approved, by BSI MD Not Approved, by BSI MD

Signature _____ Date _____

Protocol Generation

Date Order Received: _____ Progesa ID: _____

Protocol Number: _____ Patient Number: _____

Keyed Date: _____ EC: _____ Protocol Cancel Date: _____ EC: _____

Order Valid Through Date: _____

