MATAGORDA REGIONAL
MEDICAL CENTER

MRMC IV THERAPY SERVICES
PHONE: 979-241-5966
FAX: 979-241-5965

☐ **STAT REFERRAL**

PHLEBOTOMY ORDER FORM

PATIENT INFORMATION

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

HT:_____ WT:_____ Sex :( ) Male ( ) Female SSN:_____ Home #:_____ Cell#:_____

Street Address_____ City/State/Zip_____

Allergies:_____

INSURANCE INFORMATION

Primary Insurance Name_____ Policy ID #: _____

Secondary Insurance Name_____ Policy ID #:_____

PHYSICIAN / FACILITY INFORMATION

Physician Name_____ Contact Name_____ Contact Phone # _____

Address:_____ City/State/Zip_____

DEA#:_____ NPI #:_____ State Lic #:_____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (*select appropriate code*)

❑D45 Polycythemia Vera ❑D75.1 Secondary Polycythemia ❑ D75.1 Testosterone Replacement Therapy

❑E83.110 Hereditary Hemochromatosis ❑E83.118 Other Hemochromatosis ❑ Other:_____

Other (Include both ICD-10 Code and Diagnosis) _____ Date of Diagnosis: _____

Does the patient have any medical contraindications for this procedure? ❑ Yes ❑ No If Yes, what type? _____

Does the patient have venous access? ❑ Yes ❑ No If Yes, what type? _____

If No, does patient need venous access? ❑ Yes ❑ No If Yes, what type? ❑ PIV (HepLock) ❑ PIV (No HepLock – DC after each visit)) ❑ PICC ❑ MediPort

PRESCRIPTION ORDERS

a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH HEPARIN OR SALINE PER HOSPITAL PROTOCOL PRN

☐ **DO NOT ADMINISTER HEPARIN TO THIS PATIENT**

Therapeutic Phlebotomy	❑ 500 mL ❑ 250 mL	**if ≥**	**RBC** **Hgb** **Hct**		❒ Weekly ❒ Monthly ❒ Other:	
	VOLUME TO REMOVE (mL)	**PARAMETERS**	**RBC, Hgb and/or Hct VALUE**		**FREQUENCY**	**DURATION**

LABS **NOTES/INSTRUCTIONS/OTHER**

SELECT BELOW	LAB REQUESTED	FREQUENCY
X	Hgb & Hct	PRIOR TO EACH PHLEBOTOMY
	CBC w/ Diff	
	BMP	
	CMP	
	BUN/CREATININE	
	ESR	
	CRP	
	CPK	
	Other:	

FLUSHES: ❒ **10 mL NS Flush Syringe PRN** ❒ **Heparin 500 units/5 mL Flush Syringe PRN** ❒ **NS 50 mL PRN**

I have evaluated this patient, I am aware of no contraindications to this procedure, I have explained the reason for this procedure to the patient, and I will be responsible for the patient's follow-up care.

Physician's Signature_____ **Time**_____ **Date**_____

Fax completed form to the MRMC Infusion Center at 979-241-5965.
PLEASE include copies of: H+P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, THERAPEUTIC PHLEBOTOMY CONSENT FORM, and CURRENT INSURANCE INFORMATION in order for your referral to be processed.

45-4375 Rev (05/22) PHYORD

Phlebotomy Order Form

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PATIENT LABEL