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**

| | VOLUME TO REMOVE (mL) | | PARAMETERS: Iron, Ferritin, Hgb and/or Hct VALUE | | FREQUENCY | DURATION |
|---|---|---|---|---|---|---|
| **Therapeutic Phlebotomy** | ❑ 500 mL<br>❑ 250 mL | **if ≥** | **Iron**<br>**Ferritin**<br>**Hgb/Hct** | | ❒ Weekly<br>❒ Monthly<br>❒ Other: | |

## LABS

| SELECT BELOW | LAB REQUESTED | FREQUENCY |
|---|---|---|
| X | Hgb & Hct | PRIOR TO EACH PHLEBOTOMY |
| X | IRON | PRIOR TO EACH PHLEBOTOMY |
| X | FERRITIN | PRIOR TO EACH PHLEBOTOMY |
| | | |
| | OTHER: | |
| | | |
| | | |
| | | |
| | | |

## NOTES/INSTRUCTIONS/OTHER

______________________________
______________________________
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**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.**