HIGHLAND DISTRICT HOSPITAL

Therapeutic Phlebotomy Order

Patient Information

Patient Name: _____ Date of Birth: _____ Age: _____ Gender: _____
Address: _____ City: _____ State: _____ Zip: _____
Primary Phone Number: _____ Alternate Phone Number: _____

Diagnosis

Hemochromatosis Specify Type: ☐ Hereditary (E83.110) ☐ Non-hereditary (E83.118)
☐ Polycythemia (D75.1) ☐ Other: _____
Please list any conditions that we should be made aware of: (Other conditions may require additional information)
_____

Infectious Disease

Please indicate patients known infectious diseases ☐ N/A Patient has no known infectious diseases ☐ Hepatitis ☐ HIV

Minimum Hemoglobin and/or Hematocrit

Do not permit phlebotomy if Hemoglobin is < _____ g/dL and/or Hematocrit is < _____%
*Default values if not specified will be Hemoglobin 15g/dL and/or 48% for Hematocrit

Type of Phlebotomy

☐ Whole Blood (500mL*) ☐ Whole Blood ½ unit (250mL*) ☐ Other: _____
* Approximate Amount

Frequency and Duration

☐ One time only ☐ Weekly ☐ Every _____ weeks ☐ Monthly (4-week intervals) ☐ Other _____
Additional instructions, if indicated: _____
Total Number of Procedures: _____

Standing Orders

- Initiate IV access and provide 1000mL of 0.9% Sodium Chloride at a rate of 999mL/hr. for hypotension
- Provide a minimum of 120mL of oral hydration upon completion of procedure
- Monitor Patient a minimum of 15 minutes post procedure
- Stat H&H if not already completed. If already drawn, CBC and H&H are only valid for 7 days.

Service Location

Highland District Hospital IV Therapy Clinic
1275 N. High St
Hillsboro, Ohio 45133
hdhivtherapy@hdh.org
Ph: 937-840-6650(6674) Fax: 937-393-6158

Ordering Physician

Physician Printed Name: _____ Physician Signature: _____Date: _____ Time:_____

Office Address: _____ City: _____ State: _____ Zip:_____

Office Phone: _____ Fax: _____

Additional orders:

_____

_____

Please fax or email completed form to Outpatient IV Therapy