



ADULT AMBULATORY INFUSION ORDER
5/2023
THERAPEUTIC PHELEBOTOMY

NAME:
BIRTHDATE:
INSURANCE:
PROVIDER NAME:
CLINIC NAME and Phone number:

Patient identification

Weight: _____ kg Height: _____ cm Allergies: _____ Diagnosis Code: _____

Treatment Start Date: _____

****If treatment not started within 90 days, new orders with updated date/signature will be required. Otherwise, orders are valid for 1 year from signature date.** GUIDELINES FOR ORDERING:**

- 1) Send FACE SHEET and complete copy of INSURANCE information. Send H&P or most recent chart note, must be within the past 12 months.
- 2) Labs (H&H or CBC) must be drawn prior to processing phlebotomy orders. Send a copy of lab results if not available for review in Epic.

REQUIRED LABS:

- Hemoglobin & Hematocrit, STAT, every visit.
- Check here if okay to use POCT Hemoglobin if available at OPI location.

Optional labs below:

- CBC with differential, routine, every _____.
- Ferritin, routine, every _____.
- Iron and Iron Binding Capacity, routine, every _____.
- Other: _____ routine, every _____.

THERAPEUTIC PHELEBOTOMY: (a holding parameter must be completed)

- Remove 450 ml of blood.
- HOLD phlebotomy for **Hgb less than** _____.

OR

HOLD phlebotomy for other lab parameter: _____ less than _____. **Alert:** If using ferritin as a holding parameter, patient will need it drawn a few days in advance prior to phlebotomy appointment for results to be available.

Interval: (must check one)

- This is a ONE TIME order only.
- Weekly
- Every other week
- Once monthly
- Other: _____

NURSING ORDERS:

- Insert peripheral iv if no iv access.
- May use/access CVC line and give 500 units (5ml) heparin injection for central line care.
- Sodium chloride 0.9% (NS) bolus 500 ml, PRN, for pt report of dizziness/lightheadedness, decrease in systolic blood pressure of 20mmhg or more, or systolic blood pressure less than 90mmhg after therapeutic phlebotomy.

By signing below, I represent the following:

I am responsible for the care of the patient (*who is identified at the top of this form*).

I hold an active, unrestricted license to practice medicine in Oregon.

My physician license Number is # _____ and I am acting within my scope of practice and authorized by law to order infusion of the medications and blood products described above for the patient identified on this form.

Provider's printed name: _____

Provider's signature: _____

Date: _____



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THERAPEUTIC PHLEBOTOMY**

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BIRTHDATE:
INSURANCE:
PROVIDER NAME:
CLINIC NAME and Phone number:**

Patient identification

Please complete the following intake questions.

Mobility status

- Independent
- Walker
- Wheelchair
- Fully dependent

Bariatric needs

- Yes, briefly describe _____
- No

Transportation concerns

- Yes, briefly describe _____
- No

Interpreter Service required

- Yes, language _____
- No

Please check the appropriate box for the patient's preferred infusion center location:

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> PORTLAND | Phone-503-215-6046 Fax-503-487-3582 |
| <input type="checkbox"/> WILLAMETTE FALLS | Phone-503-215-6046 Fax-503-487-3582 |
| <input type="checkbox"/> MEDFORD | Phone-541-732-7000 Fax-541-732-3939 |
| <input type="checkbox"/> HOOD RIVER | Phone-541-387-6445 Call for fax # |
| <input type="checkbox"/> SEASIDE | Phone-503-717-7650 Fax-503-470-3146 |
| <input type="checkbox"/> NEWBERG | Phone-503-537-6040 Fax-503-205-8720 |