ADVANCED
INFUSION CENTER

Therapeutic Phlebotomy Order Form

Patient Name: _____ DOB: _____

Allergies: _____ Weight: _____ lbs/kg

Diagnosis: _____ ICD 10: _____

Does the patient have a medical condition that may increase the risk of adverse reaction and require medical supervision during phlebotomy? ___ No __Yes,

please explain: _____

Type of Phlebotomy:

__500 ml __ 250ml ___ other, please explain_____

Order frequency:

___ once __Weekley ___ Every ___ week ___ Monthly ____Other, specify

Pre/Post Hydration: circle either Pre or Post and check box for the volume

___ 500 ml ___ 250ml

Lab must be drawn and resulted 24 hours before phlebotomy at Quest Lab.

Do not perform phlebotomy if (all cut-off values MUST be included):

HGB is less than: _____ HCT is less than: ____ Ferritin is less than: _____

Physician signature: _____ Date: _____

Physician name (printed): _____

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