Blood Center Use only	
Processed by	
Verified by	

Therapeutic Phlebotomy Department
Time Square, 660 SW 39th Street, Suite 245, Renton, WA 98057
(800) 266-4033 or (425) 453-5098 Fax (425) 251-1977
Email: therapeuticphlebotomy@bloodworksnw.org

Therapeutic Phlebotomy Order Form - Hemochromatosis Maintenance

The following must be submitted before the patient may be scheduled

- ❑ **Therapeutic Phlebotomy Order Form**
- ❑ **Supporting laboratory test results with recent ferritin.**

A written rationale of medical necessity must be submitted for special requests.

Examples of required supporting documentation:

- -

First time treatment at Bloodworks

❑ **Maintenance Phase Order Form**

❑ **Laboratory reports for ferritin monitoring over the preceding year, one of which must be from within the last month.**

Please submit the completed Therapeutic Packets to the Therapeutic Phlebotomy Department by Fax or Mail.

Bloodworks

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Therapeutic Phlebotomy Order Form - Hemochromatosis, Maintenance Phase

(Order expires every 12 months)

Patient's Legal Name_____ _____ _____
Last First Middle Name or Initial

❑ **Male** ❑ **Female** **Patient's Birthdate** ___/____/_____ **Best Contact Phone #** (____)_____ **e-mail**_____

Patient's Address _____ _____ _____ _____
Street City State Zip Code

Diagnosis: ICD10 code _____

❑ **Hereditary hemochromatosis (both alleles mutated by genetic testing)**
❑ **Unspecified (Presumed Hereditary hemochromatosis without confirmatory genetic testing performed)**

Maintenance phase: Orders for maintenance phlebotomy (≤12 times a year), must be resubmitted every year, accompanied by the ferritin monitoring results over the prior year of therapy including one result since the last treatment.

Volume per phlebotomy: Orders for patients with conditions creating increased sensitivity to volume loss (e.g. elderly, pre-existing anemia, cardiac disease, lung disease, etc.) may be for less than 500 mL. Patients requiring concurrent intravenous hydration must be drawn at the Seattle Central Bloodworks location

❑ Collect 500mL (patient must weigh 114lbs or more)
❑ Collect <500mL:_____ (patient must weigh 114lbs or more)
❑ Collect volume based on patient weight (patient weighs less than 114lbs) ** ***this will be determined at time of collection***

Frequency:
❑ **Monthly** ❑ **Every** _____ **weeks** ❑ **Every** _____ **months** ❑ **Other**_____

Minimum Hemoglobin: Phlebotomy will not be performed if patient is already anemic (hemoglobin is less than 11.0g/dL or hematocrit less than 33%)

❑ If a ***higher*** minimum hemoglobin (hematocrit) threshold is desired due to decreased patient tolerance for anemia, please specify**: _____%**

Please identify if there are any Special Instructions or Precautions (if cardiac disease attach Bloodworks evaluation form):

_____

Health Care Provider
Signature_____ **Provider NPI**_____ **Date**_____
Printed Provider Name_____ **Phone**_____ **Fax**_____
Facility Address_____ **Email**_____

Bloodworks Physician – please sign and date once order has been reviewed and approved

Bloodworks Physician_____**Date**_____
Special Instructions for Therapeutic Phlebotomy Order Form is required ❑ Yes ❑ No