ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

❑ Puyallup Infusion Center - Fax: 253-697-5066
❑ Allenmore Ambulatory Infusion Services - Fax: 253-864-4052
❑ Auburn Infusion Services - Fax: 253-876-8282
❑ Gig Harbor Infusion Services - Fax: 253-530-8069
❑ DHEC Infusion Center - Fax: 509-755-5845
❑ North Spokane Infusion Center - Fax: 509-232-2531

ORDERS WITH CHECK BOXES When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Phlebotomy:

Patient Name:_______________________________________ Requested Date of Service: ________ /________ /________

Date of Birth: ______ /______ /_______ Patient Phone Number: (______) ________ - ____________________ ❑ May leave message

Diagnosis:

	ICD -10 Code:
❑ Hemochromatosis	❑ E83.119
❑ Polycythemia Vera	❑ D45
❑ Other__________________________	❑ ______________________________________

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs

If required documentation not received with order, scheduling of treatment will be delayed until complete information is available

☑ **IV Access:** Access and/or maintain IV site in accordance with MHS IV Therapy P&P: Peripheral IV Device Site Selection, Insertion, Maintenance, and Discontinuation; and Maintenance of Central Venous Catheters-Flushing, Dressing Changes and Removal

Phlebotomy (1 unit blood ~500 ml) every _________________ (i.e., weekly, monthly, etc.)

for total of __________

Labs recommended within 3 days of phlebotomy:

- ❑ CBC prior to phlebotomy, hold for HCT <___________OR___________
- ❑ Ferritin prior to phlebotomy, hold for <___________________________
- ❑ Iron/TIBC prior to phlebotomy, hold for ______________<_____________

Post-procedure hydration (optional)

- ❑ 500 ml NS infused over 30 minutes

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: ❑ Yes ❑ No (if yes, please send DOCUMENTATION of consent with order)

______________________________	______________________________	______________	______________
Provider Signature	Print Name	Date	Time

Another brand of drug, identical in form and content, may be dispensed unless checked ❑ **Orders expires in 12 months****

Patient Identification - Always Attach Patient Label

Name:

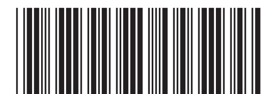
MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order

PHLEBOTOMY



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