

ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

Fax all infusions to: 833-380-8800
Please mark the appropriate
infusion center:

- Allenmore Infusion Center
- Auburn Infusion Center
- Gig Harbor Infusion Services
- Puyallup Infusion Center
- DHEC Infusion Center
- North Spokane Infusion Center
- North Star Lodge Infusion Center

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:

- Hemochromatosis
- Polycythemia Vera
- Other _____

ICD -10 Code:

- E83.119
- D45
- _____

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

MultiCare 

