Eaton Rapids Medical Center Specialty Clinics
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Therapeutic Phlebotomy Order

Patient Name: _____ Allergies: _____

Date of Birth: _____ Height: _____ Weight: _____

Diagnosis:

☐ Hereditary Hemachromatosis ☐ Polycythemia, Primary ☐ Non Hereditary Hemachromatosis
☐ Polycythemia, Secondary ☐ Other: _____

Vitals:

☐ Baseline T, HR, RR, BP, SpO2 prior to initiation of procedure and immediately post procedure.

Monitoring:

☐ Monitor for adverse reaction

Lab Orders:

☐ Frequency of lab draw: _____

Please provide parameters for the following: Hgb _____ Hct _____

☐ Draw Hgb/Hct post phlebotomy

Phlebotomy Orders:

Volume to be removed:

☐ Whole Unit (500mL)
☐ Half Unit (250mL)
☐ Other: _____

Frequency:

☐ Every 2 weeks
☐ Monthly (every 4 weeks)
☐ Other: _____

Fluid Replacement:

☐ Administer 0.9% Sodium Chloride 250 mL bolus immediately following phlebotomy
☐ Administer 0.9% Sodium Chloride 500 mL bolus immediately following phlebotomy
☐ Administer _____ for B/P less than _____

Patients will be discharged home after treatment is complete and vitals are stable unless ordered otherwise.

_____ _____
Ordering Physician Name Contact Phone Number

_____ _____ _____
Date Time Ordering Physician Signature