Sparrow
Herbert-Herman
Cancer Center

Sparrow Infusion Center

Phone: (517) 364-9402
Fax: (517) 487-3148

Legal Patient Name:	**DOB:**
ICD 10 Diagnosis Code:	**Diagnosis:** ☐ Polycythemia ☐ Polycythemia Vera ☐ Hemochromatosis ☐ Hereditary Hemochromatosis ☐ Other _____

THERAPEUTIC PHLEBOTOMY ORDERS

Parameters

- ☐ Remove _____ mL of blood
- ☐ Select applicable parameter below:
  - HOLD if hemoglobin is below _____
  - HOLD if hematocrit is below_____
  - HOLD if ferritin is below_____
  - Other _____

Frequency & Duration

* Must be a defined timeframe “as needed” is not acceptable.

- ☐ One time
- ☐ Weekly for a total of _____ procedures
- ☐ Every ____ weeks for a total of _____ procedures
- ☐ Other _____

Labs

Date of most recent lab result _____

*MUST include copy of most resent lab results (unless results are found in EPIC)

*Ordering provider is responsible for monitoring labs throughout the duration of this order

*Sparrow Infusion Center will only VERIFY that patient meets parameters for therapeutic phlebotomy

Printed Provider Name: _____Office Phone: _____

Provider Signature: _____Date: _____Time: _____