THERAPEUTIC PHLEBOTOMY ORDER FORM

Patient Information:

Name:	DOB (dd/mm/yyyy)	PHN:	Emergency contact:
Address:	Allergies:	Phone number:	Alternate phone number:

Prescriber Information:

Name:	Phone number:	Fax number:

Clinical Information:

Diagnosis: ____

Recent Ferritin level: ____________________ Hemoglobin: ____________________

Has patient received therapeutic phlebotomies in the past? Details:

Prescription:

Therapeutic phlebotomy every: ☐ Week ☐ Month

Patient must have updated bloodwork before and between each phlebotomy treatment.

Please have physician import parameters for hemochromatosis and polycythemia vera.

If bloodwork does not fall into these parameters phlebotomy will be held and reassessed after updated blood work received.

Please provide laboratory requisition to patient to monitor CBC and ferritin prior to each phlebotomy.

Therapeutic phlebotomy to be performed at:

☐ SRx Clinics (SRx will arrange infusion appointments)
☐ AHS day medicine (prescriber to arrange infusion appointments)

Prescriber Signature: ______________________________ **Date:** _________________________

Procedure fee of 40$ will apply if therapeutic procedure is performed at SRx Clinics. Patient will be provided with a receipt to be used in health spending account (if applicable) or for income tax purposes. Patients will be scheduled at a SRx Clinic within 7 days of the pharmacy having received payment. Prescriber will be provided with post procedure report once therapeutic phlebotomy has taken place. Prescriber will be notified if SRx is unable to reach patient, or patient elects to not proceed with the procedure.

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