BEAUMONT INFUSION CENTERS
THERAPEUTIC PHLEBOTOMY

Location: ☐ **Royal Oak FAX: 248- 551-3168** ☐ **Troy FAX: 248-964-2409** ☐ **Lenox FAX: 947-523-4061** ☐ **Wayne FAX: 734-467-2505**
☐ **Grosse Pointe FAX: 586-498-4497** ☐ **Farmington Hills FAX: 248-471-8217** ☐ **Dearborn FAX: 313-593-8551**

Patient Name:	**Date of Birth:**	**Medical Record #:**
Physician Name:	**Address:**	**Office #:**
Diagnosis:		**Diagnosis Code (ICD-10):**

PATIENT INFORMATION

Please attach these *required* documents to Prescription (if not in EPIC):

- Copy of Insurance Card
- Labs
- Supporting clinical documentation
- Patient Demographics

☐ **NKDA**

☐ **Drug Allergies:** _____

Height: _____ ft _____ in **Weight:** _____ kg / lbs **Date:**_____

Current Laboratory Results: CBC REQUIRED WITHIN 7 DAYS OF THERAPY:

Date Drawn:_____ Hgb:_____ HCT: _____ Platelets:_____

For Hemochromatosis, Ferritin must be drawn within last 3 months:
Date of Draw: _____ Results:_____

THERAPEUTIC PHLEBOTOMY FOR:	PROCEDURE	# Treatments
Polycythemia	☐ Remove _____ml blood per protocol • Proceed if Hgb ≥ _____ (REQUIRED) • Proceed if ferritin ≥ _____(OPTIONAL) ☐ Repeat therapeutic phlebotomy every _____	
Hemochromatosis	☐ Remove _____ml blood per protocol • Proceed if Hgb ≥ _____ (REQUIRED) • Proceed if ferritin ≥ _____(REQUIRED) ☐ Repeat therapeutic phlebotomy every _____	
Hydration	☐ IV Hydration of _____ml of 0.9% NS over _____ minutes ☐ Oral hydration of _____ ml water	

Physician Signature _____ **Beeper#** _____ **Date** _____ **Time**_____