PHONE: 509-637-2814 FAX: 509-493-5102

PATIENT NAME:

BIRTHDATE:

Phone:

OUTPATIENT NURSING SERVICES
Please FAX completed form.

THERAPEUTIC PHLEBOTOMY REFERRAL

DOB: _____ Allergies: _____
Height: _____ Weight: _____
Resuscitation status: □ Full Resuscitation □ DNR □ DNI □ Other _____

Diagnosis: _____

ICD-10: _____

Volume of Phlebotomy:
□ 500 mL (patient must weigh 114 lbs. or more)
□ Other: _____

Frequency: □ One time only □ Every 4 weeks □ Every 8 weeks
□ Other:_____
Start Date: _____ End Date: _____

Lab Orders: □ Hematocrit prior to phlebotomy □ CBC prior to phlebotomy
Threshold Hct: (Do not do phlebotomy if hct is below this result) □ 33% □ Other:

Required Support Documentation
□ Recent chart note or H&P
□ Is insurance Medicare?
□ Include pre-authorization by insurance if not Medicare

Referring Provider: _____

Referring Provider Phone: _____ Referring Provider Fax: _____

Shared Drive S:\surgery\OP Nur Ser Phlebotomy Referral

Hospitalist: Signature / Date: