Approved: _____

Scheduled: _____

Nursing Outpatient Services (NOPS)

THERAPEUTIC PHLEBOTOMY REFERRAL FORM

Referring Provider: _____ Phone: _____
Patient Name: _____ Phone: _____
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
□ 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

X _____
Referring Provider

Printed Name:
_____

Date:
_____

Please FAX completed form to 509-493-5102