TUALITY HEALTHCARE *An OHSU Partner* Tuality Community Hospital Phone: 503-681-1255 Fax: 503-681-1897 Admit to Ambulatory Services **Therapeutic Phlebotomy**	PATIENT NAME: BIRTHDATE: Page 1/1
ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK ( ) TO BE ACTIVE.	

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code:_____

This plan will expire after each transfusion at which time a new order will need to be placed**

GUIDELINES FOR PRESCRIBING:

1. Send patient contact information, H&P or most recent chart note, labs and Prior Authorization Form.

LAB ORDERS to be drawn prior to Therapeutic Phlebotomy. Labs that are dependent to administration please instruct patient to go to outpatient lab 24 hours prior to medications.

Therapeutic Phlebotomy

- ❑ Special Parameters___Hold if hgb less than 12__
- ❑ 6..Phlebotomy____400_____mls Frequency_____

Instructions_____

- ❑ Goal of therapy _____

NURSING COMMUNICATIONS

- ❑ _____

Discharge patient when transfusion complete

BY SIGNING BELOW, I REPRESENT THE FOLLOWING:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ _____
My physician license Number is # _____ ; and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.
www.Tuality/infusionorders

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax**: _____