Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO9031

ADULT AMBULATORY INFUSION ORDER

Therapeutic Phlebotomy

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING:

1. Send **FACE SHEET and H&P or most recent chart note**.
2. Labs (H&H or CBC) must be drawn within 30 days prior to phlebotomy.
3. Ferritin must be drawn within 90 days prior to phlebotomy.
    a. If phlebotomy parameters are based on Ferritin level, H/H results and parameters must be ordered at each visit to rule out anemia.

LABS:

- ☐ Hemoglobin & Hematocrit, Routine, ONCE, every visit
- ☐ Ferritin (serum), routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One
- ☐ Labs already drawn. Date: _____

NURSING ORDERS:

1. VITAL SIGNS – Pre-phlebotomy and orthostatic vital signs prior to discharge.
2. TREATMENT PARAMETERS:
    a. Perform phlebotomy if:
        i. Hgb is greater than or equal to: _____ mg/dL
        OR
        ii. Hct is greater than or equal to: _____ %
    b. Ferritin goal is: _____
3. TREATMENT PARAMETERS – Notify provider if vital signs abnormal.
4. Discharge 30 minutes after phlebotomy complete and after orthostatic vital signs are completed.
5. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

THERAPEUTIC PHLEBOTOMY:

Phlebotomize _____ mL of blood as directed (no more than 500 mL at one time).

Interval: (must check one)

- ☐ Once
- ☐ Weekly
- ☐ Every other week
- ☐ Once monthly

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

AS NEEDED MEDICATIONS:

1. Sodium chloride 0.9% bolus, 1000 mL, intravenous, AS NEEDED x 1 dose, if after phlebotomy standing SBP drops by greater than or equal to 20 points from reclined SBP OR standing DBP drops by greater than or equal to 10 points from reclined DBP and symptomatic (pallor, diaphoresis, nausea, dizziness, fainting). Contact provider if additional orders needed.

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: ☐ Oregon ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); 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.

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

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

Please check the appropriate box for the patient's preferred clinic location:

☐ **Hillsboro Medical Center**
Infusion Services
364 SE 8th Ave, Medical Plaza Suite 108B
Hillsboro, OR 97123
Phone number: (503) 681-4124
Fax number: (503) 681-4120

☐ **Adventist Health Portland**
Infusion Services
10123 SE Market St
Portland, OR 97216
Phone number: (503) 261-6631
Fax number: (503) 261-6756

☐ **Mid-Columbia Medical Center**
Celilo Cancer Center
1800 E 19th St
The Dalles, OR 97058
Phone number: (541) 296-7585
Fax number: (541) 296-7610