MISSISSIPPI VALLEY REGIONAL BLOOD CENTER

P-176: PHYSICIAN REQUEST FOR THERAPEUTIC PHLEBOTOMY

Phlebotomy will not be performed without complete information. **MVRBC** Physician must approve all orders. **MVRBC** provides this service free of charge to patients and has limited time slots. We approve orders based on medical necessity with the highest medical priority served first. Only patients with mutation positive disease will be considered for phlebotomy service. **MVRBC** reserves the right to deny service. It is the responsibility of the ordering physician to communicate with the patient on all orders. No-shows and cancellations **will not** be monitored.

Patient's Name: ____

Patient's Address: ____

Date of Birth: _______________ Patient's Home #: ___________________ Cell/Work #: ____________________

Check Patient's Diagnosis

_____**Hereditary Hemochromatosis (HH)** → **Circle one**: C282Y/C282Y or C282Y/H63D

_____**Porphyria Cutanea Tarda (PCT)**

_____**Polycythemia Rubra Vera (P. Vera)** → **Circle one**: Positive JAK2 V617F or Exon 12

_____**Polycythemia, secondary to Renal Transplant**

Required with order:

- **Laboratory Results** CBC, Iron Studies with Ferritin (genotype also required for HH and P. Vera)
- **History and Physical**
- **Medication List**

MVRBC Physician recommends phlebotomy for:

- ***Ferritin > 100***
- ***For HH or PCT, Hgb ≥ 11.5***
- ***For P. Vera, Hgb ≥ 15***

Physician's Order Request

Perform Phlebotomy if Hgb ≥: ____________________

Frequency of appointment: ______________________

Order is good for ***1 year*** *unless otherwise indicated*

NOTE:
Labs are not performed at MVRBC. Only a basic physical and Hgb are completed.

Patient Symptoms: ____

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Physician Signature: ________________________________ **Date:** _____/_____/__________

Physician (print legibly): ____

Physician's address: ____

Physician's phone: ____________________________ Physician's fax: ______________________________

Please Email patientservices@mvrbc.org or fax 563-823-8941

(Internal Use Only)

FOR MVRBC PHYSICIAN

Physician Signature ____Date_____/_____/__________

Approved ______________ **Denied** ______________

Physician Notes: ____

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NURSE DOCUMENTATION

Date Order was Received______________________________

Patient is: (circle one) New Returning Previous order and labs attached_____________

Patient Name and DOB Verified___________ Donor ID#________________ Order #_________________

Qualify for HH program Yes No Qualify for WB Yes No

Permanent Deferral Code placed______________________ (if applicable)

Patient Notification____ Date ________________________

Scheduled: _________________________Date/time: ______________________

Date Site Notified of Scheduled Appointment: ____

Date Physician's Office notified if Order was Denied: ____

Staff completing order ____**Date**_____________________

Notes: ____

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