Outpatient Therapeutic Phlebotomy Order Set

Klickitat Valley Health
Phone: 509-772-2695 Fax: 509-773-3354

General

Patient Name _____ DOB _____ Height _____ Weight _____ Phone #_____

Order Start Date _____ Order Expiration Date _____

Allergies: _____

Guidelines for Ordering:

1. Send **FACE SHEET** and **H&P** or most recent chart note.

DIAGNOSIS CODE:

☐ E83.119 Hemochromatosis ☐ D45 Polycythemia Vera

☐ Other: _____

Laboratory

☒ Verify pertinent baseline labs were obtained (must be within last 30days)

☒ Labs to be drawn every _____ weeks as an outpatient:

☐ CBC ☐ Ferritin ☐ Iron ☐ Transferrin ☐ TIBC

Nursing Orders

☒ **IV ACCESS:** Utilize Therapeutic Phlebotomy "Blood Drawing Kit, Blood Collection Bag with 16G x 1" Needle"

☒ Vital Signs: baseline and every 30 minutes until discharge. Hold patient for 30 minutes after treatment completion to observe/monitor for adverse reaction(s).

Pre-Medications

☒ May use EMLA (Lidocaine-Prilocaine 2.5%) cream prior to IV Insertion

Therapeutic Phlebotomy Order

☒ Remove _____ mL of whole blood (250-500mL as tolerated)

Frequency: ☒ Once every _____ week(s) for any of the following: ☐ Hgb greater than _____

☐ Hct greater than _____

☐ Ferritin greater than _____

IV Therapy

☐ No IV fluid replacement

☐ Administer sodium chloride 0.9% _____ mL over _____ minutes immediately following phlebotomy

MANAGEMENT OF SIDE EFFECTS

☒ Discontinue treatment for any adverse reactions, document amount of blood removed and notify provider. If afterhours call hospitalist, possible admission to emergency department for further evaluation/treatment.

OUTPATIENT NURSE- PLACE STICKER HERE

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Ordering Facility/Provider Information

By signing below, I affirm the following:

I am responsible for the care of the patent identified on this form.

I hold an active, unrestricted license to practice medicine in _____ *(specify state)*

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.

Provider Signature: _____ **Date _____**

Printed name: _____ **Phone: _____** **Fax: _____**

KVH Provider Co-signature:

**Required for all external orders*

Provider Signature: _____ **Date _____**

Printed name: _____

OUTPATIENT NURSE- PLACE STICKER HERE