Physician Order for Therapeutic Phlebotomy

Date _____________________  ✶ Order is considered valid for one year from the inception date.

Patient Name ________________________________  DOB ________________________________

Diagnosis________________________________________

One unit of blood will be drawn (approximately 500 ml) at each presentation.

✶ Frequency of Phlebotomy____________________________

✶ Minimum Hgb.__________________

✶ Minimum Hgb and Frequency must be completed or the phlebotomy cannot be performed.

Pertinent Medical History/Specific Instructions

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Name of Physician ________________________________  Signature of Physician ________________________________

Address of Physician ________________________________  Phone Number of Physician ________________________________

City/State/Zip Code ________________________________  Fax Number of Physician ________________________________

Physician E-Mail ________________________________

Verbal order taken by Signature/Date ________________________________