



AMBULATORY TREATMENT UNIT

Therapeutic Phlebotomy Order Set

Phone (616) 394-3547
Fax (616) 394-2139

= Optional Order = Routine Order (Cross out and initial **BULLETED ORDERS** that do not apply.)

ORDERS

Date: _____ Time: _____

Patient Name: _____ Date of Birth: _____ Weight: _____ (kg)

Allergies: _____

Diagnosis Code: (ICD-10) _____ Diagnosis: _____

THERAPEUTIC PHEBOTOMY ORDER

- One unit, 500 mL
- Two units, 1000 mL

Frequency

- Once
- Every _____ weeks for _____ times
- Every _____ months for _____ times
- Other: _____

May administer as needed 500ml 0.9% normal saline IV for symptomatic hypotension.

LABS

Ferritin

- STAT draw every phlebotomy. HOLD if less than _____
- Routine every _____ week / month

Hemoglobin

- STAT draw every phlebotomy. HOLD if less than _____
- Routine every _____ week / month

Hematocrit

- STAT draw every phlebotomy. HOLD if less than _____
- Routine every _____ week / month

Other Labs: _____

Provider Signature: _____ Date: _____

Provider Name and Credentials (please print): _____ Time: _____

Office Phone: _____ Office Fax: _____

