Therapeutic Phlebotomy

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**

LABS:

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

THERAPEUTIC PHLEBOTOMY:

Amount to be removed: ____________ mL, ONCE (no more than 500 mL at one time)

  Interval: (must check one)
  ☐ Once
  ☐ Weekly
  ☐ Every other week
  ☐ Once monthly

NURSING ORDERS:

1. TREATMENT PARAMETERS:
   a. Perform phlebotomy if:
      i. Hgb is greater than: ____________ mg/dL
      ii. Hct is greater than: ____________ %
   b. Other: ______________________________________
   c. Ferritin goal is: __________________

2. VITAL SIGNS – Pre-phlebotomy and every 30 minutes
3. TREATMENT PARAMETERS – Notify provider if vital signs abnormal.
4. Discharge 30 minutes after phlebotomy complete or when stable.
5. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.
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: ____________

OLC Central Intake Nurse:
Phone: 971-262-9645 (providers only) Fax: 503-346-8058

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

☐ Beaverton
OHSU Knight Cancer Institute
15700 SW Greystone Court
Beaverton, OR 97006
Phone number: 971-262-9000
Fax number: 503-346-8058

☐ NW Portland
Legacy Good Samaritan campus
Medical Office Building 3, Suite 150
1130 NW 22nd Ave.
Portland, OR 97210
Phone number: 971-262-9600
Fax number: 503-346-8058

☐ Gresham
Legacy Mount Hood campus
Medical Office Building 3, Suite 140
24988 SE Stark
Gresham, OR 97030
Phone number: 971-262-9500
Fax number: 503-346-8058

☐ Tualatin
Legacy Meridian Park campus
Medical Office Building 2, Suite 140
19260 SW 65th Ave.
Tualatin, OR 97062
Phone number: 971-262-9700
Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders