Billings Clinic

Blood Bank/Transfusion Service
Fax: 406-238-5031
Email: therapeuticphleb@billingsclinic.org

Therapeutic Phlebotomy Order Form

Notes and Instructions

- Orders are valid for a maximum of 12 months. Certain requests or changes to an existing order are subject to Billings Clinic Medical Director approval.
- Form must be filled out entirely. Incomplete forms will be returned.
- Lab test to be monitored will be ordered, resulted, and evaluated prior to each TP.
- Medical Director review/approval can take up to 2-weeks. Please plan accordingly. If urgent issues arise call 406-657-4732 and discuss with Blood Bank System Coordinator

Patient Name: _____ Sex: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Primary Phone Number: _____ Cell Phone Number: _____

The conditions below can be associated with increased risk for symptoms resulting from blood loss through therapeutic phlebotomy procedures (approximately 10% blood volume loss). Please check all that apply:

☐ Angina ☐ Myocardial Infarction (Dates:_____) ☐ Restrictive Cardiomyopathy
☐ Congestive Heart Failure ☐ Hypertrophic Cardiomyopathy/Subaortic Stenosis ☐ Other: _____
☐ Hearth Valve Disease ☐ Dysrhythmia

Diagnosis, Laboratory Thresholds, Draw Volume and Frequency (Required)

Diagnosis

☐ Polycythemia Vera ☐ Porphyria Cutanea Tarda (PCT)
☐ Hemochromatosis ☐ Other Diagnosis: _____

Frequency	Lab test to be monitored	Volume to be removed	Diagnosis Code
☐ Weekly	☐Perform TP if Hgb is ≥ _____	☐ 500 mL (1 unit)	**ICD-10: _____**
☐ Monthly	☐Perform TP if Hct is ≥ _____	☐ 250 mL (1/2 unit)	
☐ Every _____Months	☐Perform TP if Ferritin is ≥ _____	☐ Other: _____ mL	
☐ Other: _____	☐ Other _____		

Ordering Provider Information

Requesting Provider: _____ Phone Number: _____ Fax Number_____

Address: _____ Person Completing Form: _____

To the best of my knowledge, this patient ☐ is ☐ is not likely to be adversely affected by the loss of approximately 10% of their blood volume.

Provider Signature: _____ Date: _____

Billings Clinic Laboratory Use Only

Date Order Received: _____ Reviewer Signature: _____

Valid Through Date: _____ Medical Director Signature: _____ Date: _____