Regional Pre-Printed Orders for
THERAPEUTIC PHLEBOTOMY

DRUG & FOOD ALLERGIES

- Mandatory  □ Optional: Prescriber check (✓) to initiate, cross out and initial any orders not indicated.

- Indication for phlebotomy:
  □ Hemochromatosis
  □ Polycythemia
  □ Iron Overload due to ________________
  □ Other:__________________________

- Volume per phlebotomy:
  □ 500mL
  □ 200mL
  □ ___ mL

- Frequency of phlebotomies:
  □ One time only  □ Weekly  □ Monthly  □ Once every ___ weeks  □ Other:____________________
  □ Once every____ week(s) if: □ HCT greater than 0.45g/L OR ____________
     □ Ferritin greater than 50mcg/L OR ____________
  □ Hold if Hgb less than ________________

- Labs:
  □ Labs to be drawn every________ week(s)  □ Labs to be drawn 48 hours prior to phlebotomy
  □ Ferritin  □ CBC  □ Iron  □ Transferrin  □ TIBC

Duration of phlebotomies:
  □ _____ weeks  □ _____ months  □ _____ phlebotomies  □ Until ferritin less than ___ mcg/L

Date (dd/mm/yyyy)    Time    Prescriber Signature    Printed Name and College ID#