



<i>Blood Center Use only</i>	
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Therapeutic Phlebotomy Department
 Time Square, 660 SW 39th Street, Suite 245, Renton, WA 98057
 (800) 266-4033 or (425) 453-5098 Fax (425) 251-1977
 Email: therapeuticphlebotomy@bloodworksnw.org

**Therapeutic Phlebotomy Order Form -
 Hemochromatosis Maintenance**

The following must be submitted before the patient may be scheduled

- Therapeutic Phlebotomy Order Form
- Supporting laboratory test results with recent ferritin.

A written rationale of medical necessity must be submitted for special requests.

Examples of required supporting documentation:

 First time treatment at Bloodworks

- Maintenance Phase Order Form
- Laboratory reports for ferritin monitoring over the preceding year, one of which must be from within the last month.

Please submit the completed Therapeutic Packets to the Therapeutic Phlebotomy Department by Fax or Mail.



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Therapeutic Phlebotomy Order Form - Hemochromatosis, Maintenance Phase
 (Order expires every 12 months)

Patient's Legal Name _____			
Last	First	Middle Name or Initial	
<input type="checkbox"/> Male <input type="checkbox"/> Female	Patient's Birthdate ___/___/___	Best Contact Phone # (____) _____	e-mail _____
Patient's Address _____			
Street	City	State	Zip Code

Diagnosis: ICD10 code _____

Hereditary hemochromatosis (both alleles mutated by genetic testing)
 Unspecified (Presumed Hereditary hemochromatosis without confirmatory genetic testing performed)

Maintenance phase: Orders for maintenance phlebotomy (≤12 times a year), must be resubmitted every year, accompanied by the ferritin monitoring results over the prior year of therapy including one result since the last treatment.

Volume per phlebotomy: Orders for patients with conditions creating increased sensitivity to volume loss (e.g. elderly, pre-existing anemia, cardiac disease, lung disease, etc.) may be for less than 500 mL. Patients requiring concurrent intravenous hydration must be drawn at the Seattle Central Bloodworks location

Collect 500mL (patient must weigh 114lbs or more)
 Collect <500mL: _____ (patient must weigh 114lbs or more)
 Collect volume based on patient weight (patient weighs less than 114lbs) **** this will be determined at time of collection**

Frequency:
 Monthly Every _____ weeks Every _____ months Other _____

Minimum Hemoglobin: Phlebotomy will not be performed if patient is already anemic (hemoglobin is less than 11.0g/dL or hematocrit less than 33%)
 If a **higher** minimum hemoglobin (hematocrit) threshold is desired due to decreased patient tolerance for anemia, please specify: _____ %

Please identify if there are any Special Instructions or Precautions (if cardiac disease attach Bloodworks evaluation form):

Health Care Provider
Signature _____ **Provider NPI** _____ **Date** _____
Printed Provider Name _____ **Phone** _____ **Fax** _____
Facility Address _____ **Email** _____

Bloodworks Physician – please sign and date once order has been reviewed and approved

Bloodworks Physician _____ **Date** _____
 Special Instructions for Therapeutic Phlebotomy Order Form is required Yes No