



**General**

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Phone # \_\_\_\_\_  
Order Start Date \_\_\_\_\_ Order Expiration Date (max one year) \_\_\_\_\_  
Allergies: \_\_\_\_\_

**Guidelines for Ordering:**

- 1. Send **FACE SHEET** and **H&P** or most recent chart note.

**DIAGNOSIS CODE:**

- E83.119 Hemochromatosis  D45 Polycythemia Vera
- Other: \_\_\_\_\_

**Laboratory**

- Verify pertinent baseline labs were obtained (must be within last 30days)
- Labs to be drawn every \_\_\_\_\_ weeks as an outpatient:
  - CBC  Ferritin  Iron  Transferrin  TIBC

**Nursing Orders**

- IV ACCESS:** Establish peripheral IV access as needed. May use Therapeutic Phlebotomy Collection Kit.
- Vital Signs: baseline and every 30 minutes until discharge. Hold patient for 30 minutes after treatment completion to observe/monitor for adverse reaction(s).

**Pre-Medications**

- May use EMLA (Lidocaine-Prilocaine 2.5%) cream prior to IV Insertion

**Therapeutic Phlebotomy Order**

- Remove \_\_\_\_\_ mL of whole blood (250-500mL as tolerated)  
Frequency:  Once every \_\_\_\_\_ week(s) for any of the following:  Hgb greater than \_\_\_\_\_  
 Hct greater than \_\_\_\_\_  
 Ferritin greater than \_\_\_\_\_

**IV Therapy**

- No IV fluid replacement
- Administer sodium chloride 0.9% \_\_\_\_\_ mL over \_\_\_\_\_ minutes immediately following phlebotomy

**MANAGEMENT OF SIDE EFFECTS**

- Discontinue treatment for any adverse reactions, document amount of blood removed and notify provider. If afterhours call hospitalist, possible admission to emergency department for further evaluation/treatment.

Patient Name:  
DOB:



**Ordering Facility/Provider Information**

**By signing below, I affirm the following:**

I am responsible for the care of the patient identified on this form.

I hold an active, unrestricted license to practice medicine in \_\_\_\_\_ (*specify state*)

My physician license number is # \_\_\_\_\_ 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.

<b>Provider Signature:</b> _____	<b>Date</b> _____
<b>Printed name:</b> _____	<b>Phone:</b> _____
<b>Fax:</b> _____	

<b>KVH Provider Co-signature:</b> <i>*Required for all external orders</i>	
<b>Provider Signature:</b> _____	<b>Date</b> _____
<b>Printed name:</b> _____	

<i>Patient Name:</i>
<i>DOB:</i>