versiti

Prescription for Therapeutic Phlebotomy

Instructions: Complete Sections 1-3. All sections must be complete prior to faxing to Versiti. Incomplete forms cannot be processed. Contact the Special Patient Services Department at (414) 937-6188 with questions or to change the therapeutic phlebotomy order.

Section 1: PATIENT INFORMATION

Patient Name (Last, First):____ **DOB** (mm/dd/yy):______________

Gender: ☐ Male ☐ Female **Patient Contact Phone #s Home:**(____)___________ **Work:**(____)___________

Diagnosis: (Choose One)
- ☐ Hereditary Hemochromatosis (HH)
- ☐ Polycythemia Rubra Vera (PRV)
- ☐ Porphyria
- ☐ Hemochromatosis (other causes)
- ☐ Secondary Polycythemia
- ☐ Other: ______________________________

Current Hemoglobin:________________________ (g/dL), if available.

Current Ferritin*:___________________________ (ng/mL) *For HH or iron overload patients only

- **Versiti will not accept a prescription for a patient with Hgb less than 12 g/dL.**
- **If Ferritin is less than 50 ng/mL, the patient may not be phlebotomized more than once every two months.**

Section 2: PHLEBOTOMY ORDER

Please note that new prescriptions are required after 6 months or 8 phlebotomies.

Frequency of Phlebotomy: (Choose One)
- ☐ Once a Week
- ☐ Every 2 Weeks
- ☐ Monthly
- ☐ Every 2 Months
- ☐ Every 3 Months
- ☐ PRN (No more than 1 Phlebotomy Per Week)
- ☐ Other ____

Phlebotomy Volume to Withdraw: (Choose One)
- ☐ One unit of whole blood (Approximately 470-500 mL)
- ☐ Specific amount _________mL (Maximum amount in one phlebotomy is 500 mL)

Only hemoglobin levels are available at drawing sites.
Hemoglobin level is generally equivalent to Hematocrit ÷ 3. Please specify hemoglobin level.
Per Versiti policy, donor will not be drawn if hemoglobin is lower than 12 g/dL.

Do not draw if **hemoglobin** is less than ____________ (g/dL). ***(Required)***

Section 3: PHYSICIAN INFORMATION

Physician must sign this form for prescription to be valid.

Physician Signature:____________________________________ **Date:**__________________
(No PA-C signatures accepted)

Physician Office Contact:_________________________________ **Contact Phone#:**(____)___________

Mail Phlebotomy Report to: *(Required)*
____
____
____

Fax Phlebotomy Report to: (____)___________

All sections must be complete prior to faxing to Versiti.

Fax completed prescriptions to (414) 933-6833 or email to SPSAlerts@versiti.org

New forms may be obtained by visiting:
www.versiti.org → Medical Professionals → Specialty Products & Services → BloodCenter of Wisconsin → Therapeutic Phlebotomy

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