Winter Haven Hospital
BayCare Health System
Community Blood Center

460 First St. North, Winter Haven, FL 33881
Telephone (863) 297-1840
Fax (863) 291-6704
whhcommunitybloodcenter.org

THERAPEUTIC PHLEBOTOMY ORDER

To the Physician:

Thank you for entrusting the health of your patient to Winter Haven Hospital Community Blood Center.

- Complete, sign, and return this form to the blood center prior to the phlebotomy. **To avoid delays all fields must be competed.**
- For standing orders, indicate the frequency of the donation and the minimum hemoglobin limit. Note that the blood center can only determine hemoglobin values. Monitoring of other values (ferritin, etc.) must be done at the doctor's office.
- This order is valid for 1 year. *If the order is incomplete, the donor will not be drawn.*

PATIENT INFORMATION			
Last Name:	First Name:	Middle Name	
Street Address	City	State	Zip
Phone	DOB	SS# or last 4 digits of SS#	
Does the patient have a medical condition that may increase the risk of adverse reaction and require special medical supervision during phlebotomy? ☐ No ☐ Yes Explain: _____			

INDICATION FOR PHLEBOTOMY	
☐ 238.4 / D45 Polycythemia Vera (Primary) ☐ 289.0 / D75.1 Polycythemia or Erythrocytosis (secondary) ☐ Testosterone Replacement Therapy (TRT)* ☐ 289.6 / D75.0 Familial Polycythemia or Erythrocytosis ☐ 277.1 / E80.1 Disorders of porphyrin metabolism (includes porphyria cutanea tarda)	☐ 275.01 / E83.110 Hereditary Hemochromatosis ☐ 275.03 / E83.118 or E83.119 Other /Unspecified Hemochromatosis (acquired) (liver, myocardium) (secondary) ☐ 790.6 / R79.89 Other Abnormal Blood assays (elevated ferritin, hemoglobin, iron) ☐ Other _____ (Specify)
*** Note:** Patients with **Secondary Polycythemia due to TRT** may be evaluated for allogeneic donation every 8 weeks.	
ORDER DETAILS (Each draw removes 500 ml +/- 10% of whole blood) If a smaller volume is requested, then specify _____ mL	
FREQUENCY OF DRAW (select only one) ☐ One time only ☐ Weekly ☐ Monthly ☐ PRN ☐ Other (specify) _____	Do not draw if hemoglobin is less than: _____ g/dL. ***Note**: Default is 12.5 for females and 13.0 for males*.

ORDERING PHYSICIAN INFORMATION			
Physician Printed Name	Nurse Practitioner Printed Name (if applicable) *If signed by NP the printed name of the physician is also required*		
Address	City	State	Zip
Phone #	Fax #	Office Contact	
Signature of Physician or NP	State License #	Date	