ROSS MEMORIAL HOSPITAL
Kawartha Lakes

Name_____ DOB _____
mm/dd/yyyy
OHIP # _____
MRN _____ CSN_____

Weight (kg) _____ Height (cm)

Allergies ☐ NKA Or Specify: _____

FAX completed order set **to Ambulatory Care Centre 705-328-6076**

ACTION & INITIAL	DATE & TIME	Therapeutic Phlebotomy Order Set Ambulatory Care Centre

☒ This order cancels all previous orders for phlebotomy for this patient

Indications

☐ Hemochromatosis ☐ Porphyria Cutanea Tarda ☐ Polycythemia Vera ☐ Polycythemia ☐ Other

Vitals/Monitoring

☒ Baseline T, HR, RR, BP, SpO^2 prior to initiation of the procedure
☒ T, HR, RR, BP, SpO^2 immediately post procedure
☒ Monitor for adverse reactions such as nausea, shortness of breath, chest pain and orthostatic hypotension

Lab Investigations

☐ CBC ☐ Ferritin
☐ No bloodwork needed before each phlebotomy **OR**
☐ Pre-phlebotomy bloodwork via venipuncture in the lab **OR**
☐ every _____ weeks via venipuncture ☐ pre-phlebotomy ☐ 15 mins post-phlebotomy

Parameters for holding:

☐ Hold if Hemoglobin is less than 120 g/L **OR** _____
☐ Hold if Hct less than 0.42 (female) 0.45 (male) **OR** _____
☐ Hold if Ferritin is less 50 mcg/L **OR** _____

Phlebotomy Procedure

☒ Perform therapeutic phlebotomy
Remove: ☐ 250 mL ☐ 500 mL **OR** ☐ _____ mL of whole blood
Frequency: ☐ once every _____ week(s) **OR** _____ month(s) X _____ (number of times)

☒ Discontinue treatment for any adverse reactions.
☒ Document amount of blood removed
☒ Notify physician immediately
☒ Make arrangement to transfer to ED if required

Additional Orders/Comments

_____
_____
_____

Discharge

☒ Instruct patient to drink _____ mL of fluid prior to discharge
☒ Discharge when phlebotomy complete and no signs of adverse reaction

Ordering Physician/Regulated Health Care Provider, Designation	Signature	Date	Time
☐ If Telephone Order	Physician Name	Date	Time
Orders Transcribed By	Signature	Date	Time