Holland Hospital

AMBULATORY TREATMENT UNIT

Therapeutic Phlebotomy Order Set

Phone (616) 394-3547
Fax (616) 394-2139

☐ = Optional Order ● = Routine Order (Cross out and initial **BULLETED ORDERS** that do not apply.)

ORDERS

Date: _____ **Time:** _____

Patient Name: _____ **Date of Birth:** _____ **Weight:** _____ (kg)

Allergies: _____

Diagnosis Code: (ICD-10) _____ **Diagnosis:** _____

THERAPEUTIC PHLEBOTOMY ORDER

☐ One unit, 500 mL

☐ Two units, 1000 mL

Frequency

☐ Once

☐ Every _____ weeks for _____ times

☐ Every _____ months for _____ times

☐ Other: _____

☑ May administer as needed 500ml 0.9% normal saline IV for symptomatic hypotension.

LABS

Ferritin

☐ STAT draw every phlebotomy. HOLD if less than _____

☐ Routine every _____ week / month

Hemoglobin

☐ STAT draw every phlebotomy. HOLD if less than _____

☐ Routine every _____ week / month

Other Labs: _____

Provider Signature: _____ Date: _____

Provider Name and Credentials (please print): _____ Time: _____

Office Phone: _____ Office Fax: _____