



Blood Center Use only

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Therapeutic Phlebotomy Department  
Time Square, 660 SW 39<sup>th</sup> Street, Suite 245, Renton, WA 98057  
(800) 266-4033 or (425) 453-5098 Fax (425) 251-1977  
Email: therapeuticphlebotomy@bloodworksnw.org

**Therapeutic Phlebotomy Order Form -  
Hemochromatosis Rapid Iron Removal Phase**

(Order only valid for 3 months)

Patient's Legal Name <u>Ware William Michael</u>			
Last		First	Middle Name or Initial
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Patient's Birthdate <u>01/5/50</u>	Best Contact Phone # <u>253-740-6537</u> e-mail <u>trumper492@comcast.net</u>	
Patient's Address <u>2810 U St E Auburn WA 98002</u>			
Street		City	State Zip Code
Diagnosis: ICD10 code <u>D751</u>			
<input type="checkbox"/> Hereditary hemochromatosis (both alleles mutated by genetic testing)			
<input type="checkbox"/> Presumed Hereditary hemochromatosis without confirmatory genetic testing performed)			
<input type="checkbox"/> Iron overloading due to other causes (Medical necessity not generally accepted, submit written treatment rationale)			
<input type="checkbox"/> Hepatitis <input type="checkbox"/> Other liver disease <input checked="" type="checkbox"/> Medications/Toxins <input type="checkbox"/> Inflammatory disease <input type="checkbox"/> African iron overload			
<input type="checkbox"/> *Hemolysis <input type="checkbox"/> *Transfusional iron overload <input type="checkbox"/> *Sideroblastic anemia <input type="checkbox"/> Other _____			
<b>Initial Rapid Iron Removal Phase (up to one year):</b>			
Orders for frequent phlebotomy (more than 12 times a year) for rapid iron removal <b>must be resubmitted every 3 months</b> , accompanied by ferritin results including one value in the preceding month (CDC guidance is ferritin monitoring every 4 – 8 weeks until ferritin <1000, then more frequently, at least every 2 weeks once ferritin <100 ng/dL).			
<b>Volume per phlebotomy:</b> Orders for patients with conditions creating increased sensitivity to volume loss (e.g. elderly, pre-existing anemia, cardiac disease, lung disease, etc.) may be for less than 500 mL. Patients requiring concurrent intravenous hydration must be drawn at the Seattle Central Bloodworks location.			
<input checked="" type="checkbox"/> Collect 500mL (patient must weigh 114lbs or more)			
<input type="checkbox"/> Collect <500mL: _____ (patient must weigh 114lbs or more)			
<input type="checkbox"/> Collect volume based on patient weight (patient weighs less than 114lbs) <b>** this will be determined at time of collection</b>			
<b>Frequency:</b> (not to exceed one unit per week, if ferritin >100 ng/mL ; not to exceed one unit per month if ferritin ≤ 100 ng/mL)			
<input type="checkbox"/> One time only <input type="checkbox"/> Weekly <input checked="" type="checkbox"/> Monthly <input type="checkbox"/> Every _____ weeks <input type="checkbox"/> Other _____			
Maximum number of phlebotomies per order is 13.			
<b>Minimum Hematocrit:</b> Phlebotomy will not be performed if patient is already anemic (hematocrit less than 33%)			
<input checked="" type="checkbox"/> If a <b>higher</b> minimum hematocrit threshold is desired due to decreased patient tolerance for anemia, please specify: <u>45%</u>			

Please identify if there are any Special Instructions or Precautions (if cardiac disease attach Bloodworks evaluation form):

Health Care Provider Signature Todd Killebrew Provider NPI 168497620 Date \_\_\_\_\_  
Printed Provider Name Todd Killebrew Phone 253-682-4100 Fax 253-472-4140  
Facility Address 3315 So 23rd St #204 Tacoma Email \_\_\_\_\_

Bloodworks Physician – please sign and date once order has been reviewed and approved

Bloodworks Physician \_\_\_\_\_ Date \_\_\_\_\_

Special Instructions for Therapeutic Phlebotomy Order Form is required ☐ Yes ☐ No