

Form #APU-170.00
Rev: 24 Aug 09

**UNIVERSITY OF MICHIGAN HEALTH SYSTEM
APHERESIS PROCEDURE UNIT (APU)
PHYSICIAN ORDER FOR THERAPEUTIC
PHLEBOTOMY**

Name and UM Registration #

UM Donor Number:

PHLEBOTOMY ORDER

- Remove 500 ML* (standard volume) Remove _____ ML*
*volumes collected are approximate

<u>Diagnosis</u>	<u>ICD-9 Code</u>
<input type="checkbox"/> Hemochromatosis	275.0
<input type="checkbox"/> Porphyria Cutanea Tarda	277.1
<input type="checkbox"/> Polycythemia (primary) (rubra vera)	238.4
<input type="checkbox"/> _____	_____
(Diagnosis Required)	(ICD-9 Code Required)

- One-Time order
 Multiple Phlebotomy Order. Frequency of Phlebotomy: _____
 (Order must be renewed every 12 months.)

PATIENT CRITERIA (Optional) *NOTE: Unless otherwise specified, procedure will not be performed if Hct is < 33%.*

- Do not perform this procedure if the patient's **SPUN HEMATOCRIT*** is less than: _____.
 *Spun hematocrit will be performed at the time of phlebotomy.
 *Spun hematocrit may be higher than automated laboratory hematocrit.
- Do not perform this procedure if the patient's **most recent UMHS FERRITIN** is less than: _____

LABORATORY TEST ORDERS *NOTE: Test results are not available until after the procedure.*

TEST ORDERED	FREQUENCY
<input type="checkbox"/> CBCP	<input type="checkbox"/> With each phlebotomy <input type="checkbox"/> _____
<input type="checkbox"/> FERRITIN	<input type="checkbox"/> With each phlebotomy <input type="checkbox"/> _____
<input type="checkbox"/> _____	<input type="checkbox"/> With each phlebotomy <input type="checkbox"/> _____
<input type="checkbox"/> _____	<input type="checkbox"/> With each phlebotomy <input type="checkbox"/> _____

I have evaluated this patient, am aware of no contraindications to this procedure, have explained the reason for this procedure to the patient, and will be responsible for this patient's follow-up care.

Physician's Signature

Date

Physician's Name (Print)

U of M Doctor Number

Location (Clinic or Service)

Physician's Phone and/or Pager Number

For Blood Bank Physician Use Only:

I agree to Blood Bank / APU staff performing this procedure as requested by the patient's physician:

Blood Bank Physician

UM MD #

Date