P-176: REQUEST FOR THERAPEUTIC PHLEBOTOMY

Therapeutic phlebotomy is performed without charge by ImpactLife. We require all requested information to evaluate a patient. Walk-ins are not accommodated due to our scheduling needs. No labs can be performed except hemoglobin.

A note on indications: Polycythemia secondary to hypoxia is a physiological adaptation and not associated with high risks for hyperviscosity/thromboembolism at levels below a ≈60% hematocrit or hemoglobin below ≈20 g/dL and may impair O_2 delivery. We will not generally approve bleeding below those levels without a clinical rationale from the ordering physician. **Erythrocytosis from testosterone supplements** is best managed by dose reduction or discontinuation of the medication. Phlebotomy for this indication should *generally* be limited to urgent reduction of risk from hyperviscosity and thromboembolism.

Labs required with order: CBC, ferritin if appropriate. A genotype is required below for HH and P. Vera.

Frequency guidelines: When removing iron, a single unit phlebotomy will lower the serum ferritin by ≈25 ng/mL. A patient with hereditary hemochromatosis (HH) and a ferritin of 600 ng/mL may require as many as 20 units removed to reach 100 ng/mL In general, we would bleed such a patient every 1-2 weeks until reaching that level. When treating P. vera to lower the hemoglobin, each unit will, on average, lower the level by 1 gram/dL or the hematocrit by 3 percentage points. The frequency of bleeding should also be dictated by the urgency of the clinical situation. We will not accept "prn" orders.

Patient Name: _____Date of Birth: ____/____/_____

Home phone: ( )_____ Cell/Work phone: ( )_____

Address: _____

Check Patient's Diagnosis

□ **Hereditary Hemochromatosis (HH) Check genotype**: □ C282Y/C282Y □ C282Y/H63D
□ Other (**specify**)_____

□ **Porphyria cutanea tarda (PCT)**

□ **Other iron overload: Specify cause**_____

□ **Polycythemia rubra vera (P. Vera) Check genotype**: □ JAK2 V617F □ Other exon 12 mutant

□ **Polycythemia secondary to renal transplant**

□ **Polycythemia secondary to hypoxia: Symptoms:** _____

□ **Erythrocytosis secondary to testosterone therapy**

□ **Other indication: (Specify)**_____

Physician order (effective for 1 year maximum).

Perform phlebotomy if Hgb is ≥____g/dL.

Frequency (**check**): □ Q 1 wk. □ Q 2 wks. □ Q 1 mo. □ Q 2 mos. □ Q 3 mos. □ Q 6 mos.
□ Other (**specify**)_____

Physician Signature: _____ Date: ____/____/_____

Physician (print) _____ phone: ( )_____ fax: ( )_____

Physician's address: _____

E-mail to patientservices@impactlife.org or fax to 563-823-8941

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(Internal ImpactLife Use Only)

NURSE DOCUMENTATION

Date Order was Received_____

Patient is: (circle one) New Returning Previous order and labs attached_____

Patient Name and DOB Verified_____ Donor ID#_____ Order #_____

Qualify for HH program Yes No Qualify for Testosterone program Yes No

Qualify for WB Yes No

Permanent Deferral Code placed_____ (if applicable)

Patient notification_____ Date _____

Scheduled: _____Date/time: _____

Date site notified of scheduled appointment: _____

Date physician's office notified if order was denied: _____

Staff completing order _____Date_____

Notes: _____

FOR IMPACTLIFE PHYSICIAN

Physician signature _____Date_____/_____/_____

Approved _____ Denied _____

Physician notes: _____

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