

Allergies: _____

**Medical Day Unit (Outpatient) –
Therapeutic Phlebotomy Order Set**

Perth & Smiths Falls District Hospital (Perth Site)
Phone: (613) 267-1500 x 4234
Fax: (613) 267-2041

ACTION/DATE
TIME/INITIALS

Weight (kg): _____

Known Adverse Reactions or Intolerances

Drug No Yes (list) _____
 Food No Yes (list) _____
 Latex No Yes _____
 Other No Yes (list) _____

Diagnosis

Hemochromatosis Polycythemia Vera Porphyria Cutanea Tarda
 Other: _____

Vitals/Monitoring

Baseline HR, RR, BP prior to initiation of procedure and prn during procedure
 HR, RR, BP immediately post procedure and prn
 Monitor for nausea, shortness of breath, chest pain, and orthostatic hypotension (adverse reactions)

Lab Investigations

Prior to each phlebotomy or within 6 weeks of treatment
 CBC Ferritin
 Other: _____

Phlebotomy

Hold phlebotomy and notify prescriber if hemoglobin is less than _____ g/L
 Hold phlebotomy if ferritin is less than _____ mcg/L
 Discontinue phlebotomy if adverse reactions occur and notify prescriber immediately

Phlebotomize _____ mL q _____ until ferritin is less than
 50 mcg/L 100 mcg/L _____ mcg/L
THEN
 Phlebotomize _____ mL q _____ to maintain ferritin less than _____ mcg/L

OR
 Phlebotomize _____ mL q _____ until hematocrit is less than 0.45
THEN
 Phlebotomize _____ mL q _____ to maintain hematocrit less than 0.45

Telephone Order _____

 Ordering Practitioner, Designation Signature Date/Time (yyyy/mm/dd hhmm) Read Back

 2nd Check 2nd Check Signature Date/Time (yyyy/mm/dd hhmm) Sent to Pharmacy

