

LAWRENCE COUNTY

Memorial Hospital

DEACONESS ILLINOIS PARTNER

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

New Referral Dose or Frequency Change Order Renewal

DIAGNOSIS AND ICDE 10 CODE

<input type="checkbox"/> Hereditary Hemochromatosis	ICD-10 Code: E83.110
<input type="checkbox"/> Secondary Hemochromatosis	ICD-10 Code: E83.111
<input type="checkbox"/> Polycythemia Vera	ICD-10 Code: D45
<input type="checkbox"/> Porphyria Cutanea Tarda	ICD-10 Code: E80.1
<input type="checkbox"/> Erythrocytosis, unspecified	ICD-10 Code: D75.1
<input type="checkbox"/> Other: _____	ICD-10 Code: _____

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

<input type="checkbox"/> The signed order form by the provider	<input type="checkbox"/> Clinical/Progress notes (must be within 1 year)
<input type="checkbox"/> Patient demographics AND insurance information	<input type="checkbox"/> Labs and Tests supporting primary diagnosis
<input type="checkbox"/> Prior authorization with reference number	<input type="checkbox"/> CBC
*Pt may be required to submit a pregnancy test prior to treatment	<input type="checkbox"/> Iron Studies

PROCEDURE ORDERS

Procedure: Therapeutic Phlebotomy CPT Code: 99195
Volume to Remove: _____ mL (standard: 450–500 mL)

Frequency:

Weekly (induction phase)
 Every 2 weeks
 Every 4 weeks (Monthly maintenance)
 Every 3 months (maintenance)
 Other: _____

TREATMENT GOALS / TARGET LABS

Target Ferritin (ng/mL): _____ Target Hematocrit (%): _____
Target Hemoglobin (g/dL): _____ Hgb threshold to hold phlebotomy: _____ g/dL
Hold procedure if Hgb less than _____ g/dL or Hct less than _____ % or other: _____

PRE/POST PROCEDURE AND LAB ORDERS

- CBC prior to each procedure or Frequency: _____
- Iron studies (ferritin, serum iron, TIBC) prior to each procedure or Frequency: _____
- CMP or Frequency: _____
- IV fluid replacement: Normal Saline _____ mL during/after procedure
- Encourage oral hydration prior to and following procedure
- Other: _____
- Other: _____
- Date: _____

Duration: x6 months x 1 year

ADDITIONAL ORDERS/ INFORMAITON

PRESCRIBER INFORMATION

Provider Name:

Office Phone:

Office Fax:

Office Email:

Prescriber Signature:

Date:

Time:

ALL INFORMATION COUNTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD.

CONTACT US WITH QUESTIONS AT 618-943-8515

FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

INFUSION ORDERS – THERAPEUTIC PHLEBOTOMY