Alberta Health Services

Last Name *(Legal)*	First Name *(Legal)*	
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*	
PHN	ULI ☐ Same as PHN	MRN
Administrative Gender ☐ Male ☐ Female ☐Non-binary/Prefer not to disclose (X)		

Phlebotomy Therapeutic Recurrent Treatment

This form is intended for submitting treatment requests to hospital Day Medicine departments.

Note: As part of a pilot project, only **Red Deer Regional Hospital Centre Day Medicine** is currently set up to receive referrals through this process.

Referrals may be submitted by **physicians with admitting privileges at Red Deer Hospital**, with or without Connect Care access. All referring prescribers must include current telephone contact information and remain available to Day Medicine staff during regular business hours

Treatment Requirements

Type of Treatment	☐ New	☐ Renewal	
Consent for Treatment - Required	☐ Attached	Past Medical History - Required	☐ Attached
Current Medications - Required	☐ Attached	Relevant Blood Work	☐ Attached
Allergies			☐ No Known Allergies

Goals of Care Designation

☐ R1 ☐ R2 ☐ R3 ☐ M1 ☐ M2 ☐ C1 ☐ C2

Confirm Indication for Treatment/Problem

Select at least one

☐ Hemochromatosis

☐ Polycythemia vera

☐ Other: _____

Appointment Request

☑ Infusion Appointment Request ☐ Once ☐ Every ___ weeks for ___ treatments

Nursing Orders - Treatment Parameters

Goals and Frequency of Phlebotomy

☐ Goal of phlebotomy is hemoglobin less than ___ g/L. Phlebotomize every ___ weeks until target reached, then continue phlebotomy every ___ weeks.

☐ Goal of phlebotomy is ferritin less than ___ ug/mL. Phlebotomize every ___ weeks until target reached, then continue phlebotomy every ___ weeks.

☐ Goal of phlebotomy is hematocrit less than ___ L/L. Phlebotomize every ___ weeks until target reached, then continue phlebotomy every ___ weeks.

☐ Goal of phlebotomy is transferrin saturation less than ___ %. Phlebotomize every ___ weeks until target reached, then continue phlebotomy every ___ weeks

HOLD phlebotomy and notify the most responsible health care practitioner (MRHP) if:

☐ HOLD if hemoglobin less than ___ g/L and notify MRHP to adjust interval of appointments.

☐ HOLD if ferritin less than ___ ug/mL and notify MRHP to adjust interval of appointments.

☐ HOLD if hematocrit less than ___ L/L and notify MRHP to adjust interval of appointments.

☐ HOLD if transferrin saturation less than ___ % and notify MRHP to adjust interval of appointments.

Patient Care Orders

☑ Vital signs – per protocol

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Procedure

☑ Phlebotomy Therapeutic POC

☑ Sodium chloride 0.9% bolus 500 mL, Once, as needed – for syncope or hypotension

Post Procedure Labs

Referring provider is responsible for ordering and managing all relevant Lab tests (such as CBC with Differential, Reticulocyte Count, Ferritin, and Iron/TIBC).

Ensure appropriate lab work associated with treatment parameters are ordered and available.

Name MRHP	Designation	
Phone	Fax	Pager / Cell Phone
Signature		Date *(dd-Mon-yyyy)*

Additional Patient Information

Name of Caregiver / Guardian / Alternate Decision Maker	Relationship	Phone

Interpreter Required ☐ No ☐ Yes ► Specify Language _____

Special Considerations for Care: