BioPlus® Infusion

Fax your completed order to 877-734-1157

Patient Name: _____ DOB: _____ Date of Last Infusion: _____

Height_____ Weight_____

Infusion Location: (state and site) _____

Therapeutic Phlebotomy Orders

Diagnosis (please provide ICD-10 code):

_____ Hemochromatosis (ICD-10)

_____ Polycythemia Vera (ICD-10)

_____ Porphyria (ICD-10)

_____ Other: _____ (ICD-10) (Description)

Nursing: Hold treatment and notify provider for the following:

- Hypotension (SBP less than 90 mmHg), Tachycardia (HR greater than 120 bpm)
- Concern for dehydration or other current active illness
- Anemia or low ferritin (see parameters below) Labs

Required for Treatment:

To be drawn 3-7 days prior to appointment with results faxed to Physician

☐ CBC w/diff	☐ Ferritin	☐ Iron/TIBC/TSat

Treatment parameters- HOLD TREATMENT FOR (select all that apply):

☐ Hgb less than _____ g/dL	☐ Hct less than _____ %	☐ Ferritin less than _____ ng/mL	☐ Other: _____

Phlebotomy Orders:

☐ Withdraw 500 ml whole blood (+/- 10%)

Obtain vital signs before and after procedure.

☐ Other: _____

Total not to exceed 500 ml whole blood (+/- 10%) Hydration (please select BOTH frequency and volume)

Frequency:

- ☐ PRN for orthostasis, dizziness, lightheadedness, nausea, hypotension or if pt is otherwise symptomatic following phlebotomy
- ☐ Once pre-procedure
- ☐ Once post-procedure

Volume:

- ☐ Infuse 250 ml 0.9% sodium chloride over 15 min
- ☐ Infuse 500 ml 0.9% sodium chloride over 30 min
- ☐ Other: _____

Frequency:

- ☐ One time only
- ☐ Every _____ weeks
- ☐ Other: _____

Provider Name (print): _____ Date: _____

Provider Signature: _____ Time: _____