QUINCY VALLEY MEDICAL CENTER

Therapeutic Phlebotomy Infusion Referral

Please fax referral form with patient face sheet, insurance information, and recent office visit notes along with recent lab work to (509) 787-4865.

Referring Provider:_____

Phone Number:_____ **Fax Number:**_____

Patient's Primary Care Provider:_____

Phone Number:_____

Prescribing Provider Signature:_____ **Date:**_____

Patient Name:_____ **DOB:**_____

Phone Number:_____

Allergies:_____

Pt. Weight:_____ **Pt. Height:**_____

Diagnosis Code: [ ] **Start Date:** [ ]

Remove Blood: [ ] mL **Frequency:** [ ] **Number of Procedures:** [ ]

Pre-Phlebotomy Lab Result:

Hematocrit:	Hemoglobin:	Ferritin:
[ ] %	[ ] g/dL	[ ] ug/L

Post Phlebotomy Goal

Hematocrit:	Hemoglobin:	Ferritin:
[ ] %	[ ] g/dL	[ ] ug/L

Fluid Replacement:

Type:	Volume:	Rate:
[ ]	[ ]	[ ]