

QUICK TEST HEALTH SERVICES

7165 E. University Dr Suite 155, Mesa, AZ 85207
Where Privacy Meets Expertise

Phone: (602)-428-4557
Fax: (602)-428-4561
Email: info@quicktestservices.com

THERAPEUTIC PHLEBOTOMY — PHYSICIAN ORDER

Order valid for 12 months from order date unless otherwise specified. Incomplete forms cannot be accepted.

PLEASE NOTE: Quick Test Health Services does not offer saline or IV fluid reinfusion at time of therapeutic phlebotomy.

PATIENT INFORMATION

Full Name: _____ DOB: _____ Sex: _____
Address: _____ City/ZIP: _____
Phone: _____ Email: _____

REQUIRED — ICD-10 Diagnosis Code: _____

DIAGNOSIS (check all that apply)

Hereditary Hemochromatosis Non-Hereditary Hemochromatosis Porphyrria Cutanea Tarda
Polycythemia Vera Secondary Erythrocytosis due to Testosterone Replacement Therapy (TRT)
Secondary Polycythemia due to: _____ Other: _____

PHLEBOTOMY ORDER

Volume: Whole Blood — 1 unit (approx. 450-500 mL) Whole Blood — 1/2 unit (approx. 250 mL)
Frequency: One time only Weekly Every _____ weeks Every _____ months
Order valid for: _____ months (maximum 12)

Minimum Hemoglobin: Do not draw if Hgb below _____ g/dL **Minimum Hematocrit:** _____ %

If the Hgb field is left blank, default minimums apply: 12.5 g/dL (female) / 13.0 g/dL (male). Please fill in the field if different values are needed.

Special precautions / notes: _____

ORDERING HEALTHCARE PROVIDER (all fields required)

Provider Name: _____ State: _____ License #: _____
Practice Address: _____
Phone: _____ Fax: _____ Completed by: _____
Provider Signature: _____ **Date:** _____

TO SCHEDULE: Fax this completed order to (602)-428-4561 or email it to info@quicktestservices.com.

Include a recent CBC or ferritin result (within 24-48 hours of the planned appointment). We will call the patient to schedule — usually within a few days.