Geisinger Medical Center
Apheresis Clinic
100 N. Academy Ave
Danville PA 17822
Phone 570-271-8959
Fax 570-271-7132

Geisinger Wyoming Valley
Apheresis Clinic
1000 E. Mountain Dr.
Wilkes-Barre PA 18711
Phone 570-808-7415
Fax 570-808-3167

Apheresis Service and Therapeutic Phlebotomy Request

Amanda Haynes, DO – Director, Transfusion Medicine
Deborah Novak, M.D. – Associate Director, Transfusion Medicine

Referring Site Information:

Requesting Location: _____

Ordering Physician: (please print first and last name) _____

Contact Person: _____

Telephone: _____

Patient Information:

Patient's Name: _____

Patient's Date of Birth: _____ **Geisinger MRN (if known): _____**

Patient's Phone Number: _____

Patient's Address: _____

_____

1. For Consultation please contact a Geisinger Apheresis Clinic and ask to speak to the covering Apheresis Provider.

2. **Procedure Order**: (*check the specific treatment being requested*)
   ____ Plasma – 36514 - Therapeutic Plasmapheresis, Therapeutic Plasma Exchange, TPE
   ____ Platelet – 36513 - Plateletapheresis, Platelet Reduction
   ____ WBC – 36511 - Leuko-reduction, Leukopheresis, WBC Apheresis
   ____ RBC – 36512 - RBC Exchange, Red Blood Cell Apheresis, RBC Apheresis
   ____ ECP – 36522 – Extracorporeal Photopheresis
   ____ Therapeutic Phlebotomy

3. **Therapeutic Phlebotomy Order:** (Copy of completed *Informed Consent for Therapeutic Phlebotomy* must accompany order)

   - **Specify Hemoglobin Level threshold**: ____g/dL do not perform if below this amount (for Hemochromatosis/Iron Overload)
   OR
   - **Specify Hematocrit Level threshold**: _____% do not perform if below this amount (for Polycythemia, Erythrocytosis)

   - Specify Volume to Remove (circle amount) 450 mL; Other (Specify Volume) _____mL
   - IV Normal Saline Replacement: (Circle One) Yes or No - If Yes, specify volume to replace: _____mL
   PO fluid recommended unless low tolerance to volume loss or clinical condition warrants IV fluid replacement.

4. **Treatment Diagnosis** - _____/_____
   (Primary Treatment Diagnosis) (ICD 10 code)

Patient's Name _____
Patient's Date of Birth _____
Patient's Geisinger MRN (if known) _____

5. Treatment Plan: (For Therapeutic Phlebotomies and Apheresis Procedures)

1. Frequency: (*check appropriate interval between treatments*)
   ___ Once ___ Every Other Day ___ Twice a Week ___ Weekly ___Every Other Week ___ Monthly
   ___ Other (specify) _____

2. Duration (*specify length of time or number of treatments up to one year)*) _____

6. **Replacement Fluid** (for **Plasmapheresis Only**)
   ____ 5% Albumin ____ Other (must consult Transfusion Medicine Medical Director)
   *specify fluid type if other*_____

7. **Exchange Volume** (for **Plasmapheresis Only**)
   _____ 1 Plasma Volume Exchange _____ Other (must consult Transfusion Medicine Medical Director)
   specify volume _____

8. **RBC Replacement** (**Red Blood Cell Exchange Only**)
   Check One – supply additional required information
   ____ Apheresis Provider to calculate number of units based on patient's parameters
   ____ Number of units to Exchange (specify number of units) _____

9. **Special Lab Request**: (Please specify frequency) ___Weekly ___ Monthly ____ Other (Please Specify) _____
   ____ CBC – Complete Blood Count
   ____ CMP – Complete Metabolic Panel
   ____ BMP – Basic Metabolic Panel
   ____ LD – Lactate Dehydrogenase
   ____ PT/INR - Prothrombin Time with International Normalized Ratio
   ____ Ferritin
   ____ Renal Function Panel
   ____ IgM – Immunoglobulin M
   ____ Viscosity
   ____ Other (list) _____
   _____

10. Please have patient hold all medications containing an ACE Inhibitor for at least 24 hours prior to scheduled **plasmapheresis** treatments when 5% Albumin will be used as the replacement fluid. Consider changing blood pressure medication if patient is going to have long term Plasmapheresis Treatments. Please contact Transfusion Medicine Medical Director for further options or advice.

11. **Required Information For Initial Apheresis Treatment or Therapeutic Phlebotomy Procedure Plan:** Information from the referring provider or their designated personnel. This information can be in the form of a clinic note or copy of the office visit summary with, but not limited to, primary diagnosis for apheresis treatments or therapeutic phlebotomy procedure, the goals of the Apheresis treatment or therapeutic phlebotomy procedure and the plan to achieve said goals, criteria for discontinuation of therapy, and follow-up plan.

Patient's Name _____
Patient's Date of Birth _____
Patient's Geisinger MRN (if known) _____

12. **Required Information for Continuation of Apheresis Treatments or Therapeutic Phlebotomy Procedure: (Please supply information with all new orders)** Information from the referring provider or their designated personnel. This information can be in the form of a clinic note or copy of the office visit summary with, but not limited to, primary diagnosis for apheresis treatments or therapeutic phlebotomy procedure, information on whether or not Apheresis or the therapeutic phlebotomy procedure is effective (based on exam or history), the goals of the Apheresis treatment or therapeutic phlebotomy procedure and the plan to achieve said goals, criteria for discontinuation of therapy, and follow-up plan.

_____/_____
Physician's Name (Print) *Physician's Phone Number*

_____/_____
Physician Signature *Date*

Patient Insurance Information:

Primary Insurance Carrier and ID Number: _____

Secondary Insurance Carrier ID Number: _____