

Patient Name _____	Date of Birth _____
Address _____	Phone Home _____
_____	Work _____
_____	Mobile _____

I hereby request therapeutic venesection for the above patient who is under my care.

- I understand that the patient must meet the criteria for venesections. SNP's minimum acceptable haemoglobin for venesection is
Males: 125g/L Females: 115g/L

Please discuss with a Medical Officer at SNP if you are requesting a patient with a lower Hb than our minimum levels

- The patient has a medical condition for which venesection is indicated (haemochromatosis, polycythaemia, porphyria).
- I am aware SNP does not manage these patients and is not responsible if my patient does not attend for venesections. Regular patient review is the responsibility of the treating physician and not SNP
- I am aware that I am responsible for monitoring the patient and advising SNP of changes to the venesection schedule.
- I understand that ongoing confirmation is required from me, at least every 12 months that this patient continues to need therapeutic venesection.
- I am aware that patients may, on request, be given their Hb and Iron result by SNP staff as a guide to their progression toward the target level set by me.

Referring Doctor Name _____	
Provider Number _____	
Address _____	Signature _____
Phone _____	
Fax _____	Date _____

Please provide all requested information below on your patient. We are unable to perform venesections on patients without all relevant information.

Condition requiring therapeutic venesection	_____				
Most recent Iron Studies (please attach copies if not done at SNP or SNP lab no.)	_____				
Most recent Full Blood Count (please attach copies if not done at SNP or SNP. Lab no.)	_____				
Other Medical conditions	_____				
Recommended venesection frequency	Weekly	2 weekly	Monthly	2 monthly	3 monthly
	Other _____				
Target level for my patient	Ferritin _____ (suggested range Fn 50-100)				
	OR				
	HCT _____ (suggested level HCT <0.45)				
Volume to be collected from my patient	1 bag (500 mL)	Half bag (250 mL)	Other _____		
Patient to be reviewed by referring doctor in	3 months	6 months	12 months	Other _____	

Please hand this form and a completed Sullivan Nicolaides Pathology request form to the patient