LABORATORY NUMBER

Sullivan Nicolaides PATHOLOGY
Quality is in our DNA

Office use only:
Venesection performed by SNP Medical Officer Name: _____

Therapeutic Venesection Request Form

INSTRUCTIONS

I hereby request therapeutic venesection for the below 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 (haemochromotosis, polycythaemia, porphryia).
- **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.
- 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 CLINICIAN DETAILS

Name: _____ Phone: _____ Fax: _____

Provider No: _____ Signature: _____ Date: _____

Please provide ALL the requested information on your patient. We are unable to perform venesections on patients without all relevant information. Please disregard if you have already given this form to the patient and have received this request via fax.
NOTE: a new referral is required each 12 months; with each new referral a cost of $120 or $60* (concession) will apply.

PATIENT DETAILS

Patient Name: _____ Date of birth: _____

Address: _____ Phone: Home _____

_____ Mobile _____

_____ Work _____

PATIENT MEDICAL DETAILS

Condition requiring therapeutic venesection: _____

Most recent Iron Studies: (please attach copies if not done at SNP or SNP#) _____

Most recent Full Blood Count: (please attach copies if not done at SNP or SNP#) _____

Other medical conditions: _____

Recommended venesection frequency: ☐ weekly ☐ 2 weekly ☐ monthly ☐ 2 monthly ☐ 3 monthly
☐ other (please specify): _____

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) ☐ ½ bag (250 mL)

Note: A new referral is required each 12 months. Venesections are <u>not</u> a Rule 3 item.

Please hand this form **and** a completed Sullivan Nicolaides Pathology request form to the patient or return to us by Fax on _____.

*Correct at the time of printing - December 2016. Prices may change without notice.

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