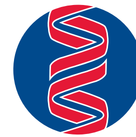
LABORATORY NUMBER



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.
NOTE: a new referral is required each 12 months; with each new referral a fee will apply. Please speak to the collector about pricing.

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 not a Rule 3 item.

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

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