

NOTE: Incomplete and / or unsigned requisitions will be returned

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

MARKHAM STOUFFVILLE HOSPITAL CORPORATION

**REFERRAL FOR
THERAPEUTIC PHLEBOTOMY**

Booking Line: (905) 472-7068

Fax: (905) 472-7544

HOURS: 7:30 TO 3:30

Appointment Date & Time: _____

Hospital MRN #: _____
Patient Name: _____ <small>Last First</small>
Date of Birth: _____ Sex: F M <small>Day Month Year</small>
Health Card # _____ Version Code: _____
Telephone # Home: _____
Other Telephone #: _____
Email: _____

Date:	Referring MD	Signature	MD Phone #
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Additional Reports to:

Translator contact information for scheduling & accompaniment (Name & Number):

DIAGNOSIS with full history note, supporting test results (eg. hemachromatosis gene testing, iron studies, ferritin, porphyria results, MRI results of liver iron overload) full medication list.

Suitability / appropriateness for TP will be reviewed for the following patients:

Cardiac history, complex medical history with multiple active medications/therapies

Exclusion criteria:

MI/ stroke within 6 months, inadequate supporting data for TP, pregnancy/postpartum state, current infection/diarrhea

Other Relevant Information:

THERAPEUTIC PHLEBOTOMY WILL BE SCHEDULED ON:
Mondays, Tuesdays and Fridays from 8.30 am with the last scheduled appointment at 2.30 pm

Signature of Referring Physician	Date
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