Therapeutic Venesection Registration Form

Attach Lab no. here
Office use only

INSTRUCTIONS

I hereby request therepeutic venesection for the below patient, who is under my care.

- I understand that the patient must meet the criteria for venesections.
- The patient has a medical condition for which venesection is indicated (haemochromatosis, polycythaemia, porphyria).
- I am aware that QML Pathology 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.
- I am aware that I am responsible for monitoring the patient and advising QML Pathology of any changes in the venesection schedule.
- I understand that ongoing confirmation is required from me.
- I am aware that my patients may, on request, be given the Hb and Iron result by QML Pathology staff as a guide to their progression towards the target level set by me.

REFERRING CLINICIAN DETAILS

Name: _____ Phone: _____ Fax: _____

Provider No.: _____ Signature: _____ Date: _____

Please provide ALL requested information on your patient. We are unable to perform venesections on patients without this information. **NOTE:** A new referral is required each 12 months. With each new referral a cost of $150 or $75* (concession) will apply.

PATIENT DETAILS

Patient Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

PATIENT MEDICAL DETAILS

Condition requiring therapeutic venesection: _____

Most recent Iron Studies (please attach results if not performed by QML Pathology): _____

Most recent Full Blood Count (please attach results if not performed by QML Pathology): _____

Other medical conditions: _____

Recommended venesection frequency:

☐ Weekly ☐ 2 Weekly ☐ Monthly ☐ 2 Monthly ☐ 3 Monthly ☐ Other (please specify) _____

Further pathology testing required at time of Venesection

☐ FBC ☐ Hb ☐ Ferritin ☐ Iron Studies ☐ E/LFT ☐ Other (please specify) _____

Target level for my patient: ☐ Ferritin _____ (suggested range Fn 50 - 100)
OR
☐ HCT _____ (suggested level HCT < 0.45)

Note: *A new referral is required each 12 months. Venesections are not a Rule 3 item.*

PLEASE HAND COMPLETED FORM TO YOUR PATIENT.

*Prices correct at time of printing and are subject to change without notice.

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