**REFERRAL FOR THERAPEUTIC VENESECTION – Polycythaemia**

**PATIENT DETAILS**

Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NHI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (Hm) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:(Wk) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:

**PATHLAB ONLY**

Haematologist reviewed: Accepted / Declined

Sign Date

Entered onto Intranet List: Initial:….…… Date …….…..

PAL App / PID Updated: N/A : Initial:…..…… Date …….…..

First appointment made: Date: ……………………….

Expiry of referral form: …………………….…

**INDICATION AND TARGET VALUE**

1.Polycythaemia – please tick indication and target Hct:

[ ]  Polycythaemia vera:

 [ ] JAK-2 V617 mutation + [ ] JAK-2 Exon sequencing +

[ ]  Hct <0.45

[ ]  Hct <0.42

[ ]  Other: please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Secondary polycythaemia: [ ]  Hypoxic pulmonary disease - Hct <0.52

 [ ]  Post-transplant Polycythaemia - Hct <0.50

 [ ]  Other1: please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* It is the referrer’s responsibility to decide on the frequency of FBC testing and ensure the patient is having such tests. A FBC will also be taken at the time of each venesection.
* Where an active referral is in place Pathlab will receive an automatic alert when such patients have a FBC checked and if Hct above target Pathlab will contact the patient to arrange venesection.

1 - There is no clinical benefit of venesection in erythrocytosis secondary to testosterone replacement therapy. It increases the risk of iron deficiency; it is generally ineffective in controlling haematocrit and not supported by current guidelines.

(Health Pathways publication awaited)

**PATHLAB ONLY VENESECTION**

Venesection Vol. ML

Please ensure tests performed

CBC

Phlebotomist Date

**VENESECTION VOLUME**

[ ]  Standard (450ml)

[ ]  Other (not exceeding 450ml): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Low weight individuals should have venesection volume capped at 7ml/kg

**Please return this completed form to: Venesection.Referral@pathlab.co.nz**

**PATHLAB ONLY VENESECTION**

Venesection Vol. ML

Please ensure tests performed

CBC

Ferritin

Phlebotomist Date

**PATHLAB ONLY VENESECTION**

Venesection Vol. ML

Please ensure tests performed

CBC

Ferritin

Phlebotomist Date

**PATIENT DETAILS**

Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NHI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**ADDITIONAL INFORMATION**

Co-mordities e.g. hypertension, COPD, IHD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REFERRING DOCTOR**

* I confirm my patient is medically fit for therapeutic venesection.
* I am aware that I remain responsible for overall monitoring of the patient and will advise Pathlab if patient becomes medically unfit or the indications for venesection change.
* I am aware that individuals who fail to attend 3 consecutive appointments will be discharged back to my care.
* I am aware that this request for venesection is valid for 1 year.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor’s signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_**

**Please return this completed form to: Venesection.Referral@pathlab.co.nz**