Therapeutic Venesection Referral

(Please email the completed referral form to: dnhaem@awanuilabs.co.nz)

Patient Surname: _____ **NHI:** _____

Patient Given Name: _____ **Date of Birth:** _____

Telephone: _____ **Email:** _____

- I request therapeutic venesection for the above patient, who is under my clinical care
- I confirm that the patient is medically fit for therapeutic venesection
- I will monitor the patient and notify Awanui Laboratories if the patient's condition changes and they are no longer medically fit for therapeutic venesection

Referring Doctor's Name: _____

Practice location: _____

Doctor's signature: _____ **Date:** _____

REASON FOR REFERRAL

☐ **Hereditary Haemochromatosis** *HFE gene status or laboratory reference*_____

☐ **Polycythaemia** *JAK2 status or laboratory reference*_____

☐ **Other:** _____

Specific venesection instructions from Specialist (if applicable):

PREFERRED SITE FOR VENESECTION (required)

INVERCARGILL (SOUTHLAND HOSPITAL)	OAMARU (OAMARU HOSPITAL)	GORE (GORE HOSPITAL)	GORE (GORE MEDICAL CENTRE)	BALCLUTHA (CLUTHA HEALTH FIRST)

VENESECTION INSTRUCTIONS (Laboratory use):

Hereditary Haemochromatosis Target: reduce ferritin to <100 ug/L **or**: _____

Blood Test Requirements:

FBE within 7 days prior to venesection. No venesection if Hb <115 g/L (women), <125 g/L (men); **Copy to GP**

Maintenance Phase: Ferritin every 3 months (no venesection if previous ferritin <50 ug/L); **Copy to GP**

Depletion Phase: Ferritin monthly.

Venesect weekly, or: _____ **Volume 450 mL (one unit), or:** _____

Polycythaemia Target: maintain haematocrit <0.45 **or:** _____

Blood Test Requirements:

FBE within 7 days prior to venesection. No venesection if HCT <0.45 **Results to GP**

Venesection frequency & volume as per instructions from Clinical Haematologist

Other/Specific or additional instructions:

☐ **APPROVE** ☐ **DECLINE**

Haematologist Name: _____ **Signature:** _____ **Date:** _____