ERYTHROPOIESIS-STIMULATING AGENTS REFERRAL FORM

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:________________lbs or ____________kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List

PRIMARY DIAGNOSIS

☐ D63.1 Anemia in Chronic Kidney Disease
☐ N18.3 Chronic kidney disease, stage 3
☐ N18.4 Chronic kidney disease, stage 4
☐ Other: ____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

☐ Please list any labs to be drawn by the infusion clinic: ______________________________

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☑ If no outside labs are immediately available, CBC will be drawn monthly.

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds
☐ Provider Prescribed: ______________________________________

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PRIMARY MEDICATION ORDER

*Retacrit may be substituted for Procrit based on payer preference.
*Any dose change will require a new order - unable to adjust dose real-time based on lab values.

☐ Retacrit __________________units SubQ every ____________ week(s) for _____________ months
☐ Procrit__________________ units SubQ every ____________ week(s) for _____________ months
☐ Other: ____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:______________________________

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

______________________________________ ______________________
Provider Signature Date