Comanche County Memorial Hospital

**Outpatient Infusion Center
Aranesp Order**

Please fax form to: 580-585-5472

Patient Information

Patient Name: _____   DOB: _____   Phone: _____   Gender   M   F

Patient Address: _____   Email: _____   Insurance: _____

Additional Information Needed

☐ Fax front/back of insurance card   ☐ Fax clinical/progress notes   ☐ Fax labs

☐ Fax patient demographics   ☐ Fax current medication list   ☐ Fax TB and Hep B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

D63.0 Anemia in neoplastic disease
D63.1 Anemia in Chronic Kidney Disease
D64.81 Anemia due to antineoplastic chemotherapy
DX: _____
DX: _____

Clinical Information:

☐ New Therapy Induction   ☐ Therapy Change   ☐ Therapy Continuation

Patient Weight: _____ lbs/_____ kg   Patient Height: _____ in/ _____ cm

Allergies: _____

Therapies Tried and Failed: _____

TB Test: Date: _____ Results: _____   Hep B Test: Date: _____ Results: _____

Does the patient have non-dialysis dependent chronic kidney disease?   Yes   or   No

Is the patient currently on dialysis?   Yes   or   No   Please indicate CKD Stage   1 2 3 4 5   Unknown

Does the patient have venous access?   Yes   or   No   If yes, What type? _____

If no, Initiate IV access

Lab Orders

☐ CBC w/out diff   ☐ CMP   ☐ ESR   ☐ CRP

Other: _____

Lab Orders to be done by

☐ Infusion Services

☐ Referring Provider

Prescription Information

☐ Aranesp Subcutaneous Injection   Dose: _____ mcg   Frequency: _____

☐ Aranesp IV   Dose: _____ mcg/kg   Frequency: _____   Rate: _____

Misc Orders

☐ PICC/ Midline/ CAD dressing to be changed every 7 days.

_____

_____

Flushes

☐ 10mL NS Flush Syringe PRN

☐ Heparin 500units/5mL Flush Syringe PRN

☐ 50ml NS Bag PRN

☐ 250ml NS Bag PRN

Standing Orders for Adverse Reactions

☐ Stop infusion and initiate NS bolus

☐ Notify Supervising physician and ordering provider

☐ Solu-Cortef 100mg SIVP signs of adverse reaction

☐ Benadryl 25mg SIVP for hives or bronchial inflammation

☐ Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis

☐ Oxygen 2-5L nasal cannula

☐ Albuterol 2.5mg inhaled PRN for chest tightness

☐ Other: _____

Prescriber Information

Physician Name: _____   Office Contact Name: _____

Contact #: _____   Fax Number: _____

Address: _____   City/State/Zip: _____

NPI#: _____   DEA#: _____   State License #: _____

_____   _____

Physician's Signature   Date   Time