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