

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/>	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: _____
- 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: _____

PRIMARY MEDICATION ORDER

- *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
 - 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:	<input type="checkbox"/> Fax:
NPI AND License:	<input type="checkbox"/> Email:

Provider Signature

Date