ERYTHROPOIESIS-STIMULATING AGENTS REFERRAL FORM

FLEXCARE INFUSION CENTERS

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: _____

_____

☐ 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

*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

FAX: (888) 219-8102 | EMAIL: orders@flexcareinfusion.com | VISIT: flexcareinfusion.com/referrals

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