

Patient Information

| | | | |
|-----------------------------------------------------------|---------------------|------------------------------------|----------------|
| Patient Name: | | DOB: | |
| Patient Home Phone: | Patient Cell Phone: | Patient Email: | |
| Emergency/Alternate Contact Name: | | Emergency/Alternate Contact Phone: | |
| NKDA | Allergies: | Weight lbs/kg: | Height: |
| Patient Status: | New to Therapy | Continuing Therapy | Therapy Change |
| Last infusion date (if applicable): | | _____ | |
| Is the patient pregnant, planning a pregnancy or nursing: | | Yes | No |
| Does the patient need interpreter services: | | Yes | No |

Provider Information

| | | | |
|----------------------------|-------|-----------------------------|------|
| Referral Coordinator Name: | | Referral Coordinator Email: | |
| Ordering Provider: | | Provider NPI: | |
| Referring Practice Name: | | Phone: | Fax: |
| Practice Address: | City: | State: | Zip: |

ICD-10 CODE

| | |
|----------------------------------------------------------------------------------------|--------------------------------------------------|
| D64.9 Anemia unspecified (includes Anemia due to medications) | N18.5 CKD, stage 5 |
| D63.1 Anemia in chronic kidney disease (select secondary code to indicate type of CKD) | N18.6 End stage renal disease |
| N18.30 CKD, stage 3 unspecified | D64.81 Anemia due to antineoplastic chemotherapy |
| N18.31 CKD, stage 3a | D61.1 Drug-induced aplastic anemia |
| N18.32 CKD, stage 3b | Other: _____ |
| N18.4 CKD, stage 4 | |

Medication Order

| | | | | | | | |
|-------------------------------|--------------|--------------|-----------------------|---------------|----|-------------------|----------------|
| Procrit (epoetin alfa) | Dose: | 50 units/kg | Other: _____ units/kg | Route: | SC | Frequency: | weekly |
| | | 100 units/kg | 40,000 units | | | | 3 times weekly |
| | | 150 units/kg | Other: _____ units | | | | Other: _____ |
| | | 600 units/kg | | | | | |

Documentation Required (Note: Send all labs, must include specific labs listed here)

Labs (Hgb, Blood Pressure, Iron)

Insurance Card (front and back)

Current Medications

History/Progress Notes

Pre-Medication Order

| | | | | | | | | |
|--------------------------------|---------|-------|-----------|-----------------------------------------|----------|----------|----|----|
| acetaminophen (Tylenol) | 500mg | 650mg | 1000mg PO | diphenhydramine (Benadryl) | 25mg | 50mg / | PO | IV |
| cetirizine (Zyrtec) | 10mg PO | | | methylprednisolone (Solu-Medrol) | 40mg IV | 125mg IV | | |
| loratadine (Claritin) | 10mg PO | | | hydrocortisone (Solu-Cortef) | 100mg IV | | | |

Other: _____

Dose: _____ Route: _____ Frequency: _____

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)
Provider Name
Provider Signature
Date

Order Expiration Date (mm/dd/yy): _____ (If not indicated order will expire one year from date signature) Check here if this is a stat order

Patient Information

| | | | | | | | |
|-----------------------------------|------------------------------------|------|---|---|----------|---|---|
| Patient Name: | DOB: | Sex: | M | F | Fasting: | Y | N |
| Patient Home Phone: | Patient Cell Phone: | | | | | | |
| Emergency/Alternate Contact Name: | Emergency/Alternate Contact Phone: | | | | | | |

Lab Test (Please circle or write in ICD-10)

| | |
|---------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| ALT R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21 | HIV VIRAL LOAD Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20 |
| AST R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21 | IgE J45.4, J45.3, L50.9, J45.40, J45.50 |
| HEPATIC FUNCTION PANEL R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21 | IgG G35, G36.0 |
| BASIC METABOLIC PANEL I10, E87.1, Z79.899, E87.5, E80.20, G35, M81.0, M81.8, N18.9 | IMMUNOGLOBULIN QUANT IgG, IgM, IgA G35, G36.0 |
| CALCIUM M81.0, M81.8 | IMMUNOGLOBULIN QUANT IgG, IgM, IgA, IgE G35, G36.0 |
| CBC (INCLUDES DIFF/PLT) I10, D64.9, Z00.00, R53.83, G35, C50.011, D70.9, D50.0, D63.1 | IRON, TIBC, FER PNL D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9 |
| CBC (H/H, RBC, WBC, PLT)s I10, Z00.00, Z13.0, D64.9, G35, C50.011, D70.9, D50.0, D63.1 | LIPID PANEL Z79.899, E78.5, E55.9, E78.00, Z00.00, E78.01, E78.2 |
| COMP METABOLIC PANEL I10, Z79.899, E78.5, E11.9, E78.2, E80.20, G35, M81.0, M81.8, N18.9 | MAGNESIUM I10, Z79.899, R25.2, E83.42, Z00.00 |
| CREATININE M81.0, M81.8, G35 | PSA R97.20, C61, N40.1, Z12.5, N40.0 |
| C-REACTIVE PROTEIN (CRP) R53.83, R79.82, M35.3, I10, M06.9, K50.90, K51.90, M32.9, L40.50 | PROTHROMBIN TIME-INR Z79.01, I48.91, I48.0, Z51.81 |
| FERRITIN D64.9, D50.9, D50.0, D50.8, Z00.00, D63.1, N18.9 | TRANSFERRIN SATURATION D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9 |
| G6PD M1A.9XX0, M1A.9XX1 | QUANTIFERON TB GOLD Z79.899, Z00.00, Z01.84, M06.9, M08.9, M45.0, L40.0, L40.50, K51.90, K50.90 |
| GROWTH HORMONE E22, C7A.1, E34 | TSH E03.9, I10, E03.8, R53.83, E06.3, E05.00 |
| HBSAG CONFIRMATION Z11.3, Z36.9, Z20.2, Z11.59, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0 | URIC ACID M10.9, E79.0, I10, Z00.00, M1A.9XX0, M1A.9XX1 |
| HEMOGLOBIN & HEMATOCRIT D50.9, D64.9, D50.0, D63.1, N18.9 | VIT B12/FOLIC ACID M89.49, E53.8, R53.83, F41.8, F41.9, E05.00 |
| HEMOGLOBIN A1C E11.9, E11.65, R73.01, Z00.00, I10 | VIT D 25- HYDROX E55.9, Z00.00, R53.83, I10, Z79.899, M81.0, M81.8 |
| HEP B SURF AG Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0 | Miscellaneous Labs Not Listed (Write In) |
| HIV 4TH GEN Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20 | |
| HIV 1/2 AB DIFF Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20 | |

Frequency

| | | |
|--------------------|------------------|-----------------------------|
| Prior to each dose | Yearly | Other: Please Specify Below |
| Lab Test: _____ | Frequency: _____ | |
| Lab Test: _____ | Frequency: _____ | |
| Lab Test: _____ | Frequency: _____ | |
| Lab Test: _____ | Frequency: _____ | |

| | | |
|---------------------------------|----------------------------|------|
| Provider Name | Provider Signature | Date |
| Provider Phone | | |
| o 888.209.8874 aleracare.com | advanced infusion centers™ | |