Center for Infusion Care
HILLSDALE HOSPITAL
Phone: (517) 212-4336 | **Fax:** (877) 249-1191
hillsdalehospital.com/infusion

☐ **STAT REFERRAL**

BONE MARROW STIMULATING AGENTS ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ in WT: _____ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA, _____

_____

Physician Name_____ Contact Name _____ Contact Phone # _____

NPI #:_____ Tax ID#:_____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY Primary Diagnosis: (ICD-10 Code plus Description)

_____

Date of Diagnosis: _____

PRESCRIPTION ORDERS

Collect CBC prior to each injection (s) and fax results to:_____

Hold injection if Hemaglobin is ≥ to _____

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
	Aranesp				
	Neulasta				
	Neupogen				
	Procrit ESRD *(Patients on Dialysis)*				
	Procrit NON ESRD				
	Retacrit ESRD *(Patients on Dialysis)*				
	Retacrit NON ESRD				
	Other:				

NOTES:_____
_____
_____

Physician's Signature _____**Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

Cosignature (If Required)_____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.