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 Infusion Center

Hold erythropoietin injections if Hemoglobin is ≥ to _12 g/dL__

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

NOTES/SPECIAL INSTRUCTIONS:

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.