NORTHEAST REGIONAL
Infusion Services
AT
Richardson
MEDICAL CENTER
PHONE: (318) 728-8237 FAX: (877) 249-1191

☐ **STAT REFERRAL**

BONE MARROW STIMULATING AGENTS ORDER FORM

PATIENT INFORMATION

Last Name: ____________________ First Name: ____________________ MI____ DOB:____________

HT: __________ in WT: ________ ☐ lbs ☐ 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 ______

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.