

Name: _____
MRN: _____
DOB: _____

Today's Date _____ Time _____

Diagnosis: Anemia secondary to CKD Other: _____

Age: _____ Height (cm): _____ Weight (kg): _____ BSA (m²): _____

ALLERGIES/Sensitivities: NKDA or _____

Start Date (at least 1 wk from today): _____ **Urgent (Call Infusion Center)**

Treatment Department: EHW OP Infusion

Appointment Requests: Tolerance: Use default, for chronic treatments order valid for 1 year

Appointment Request – Injection, 60 minutes Once
 Every 1 2 4 Week(s)

Treatment Conditions (Administer Treatment if): Once on Day 1

- Hemoglobin < 10 gm/dL (within 14 days)
- Systolic Blood Pressure LESS THAN 170 mmHg (within 8 hours)
- Diastolic Blood Pressure LESS THAN 100 mmHg (within 8 hours)
- Okay to treat. Include details here: _____

Labs: Lab (if selected) will be done as per appointment frequency selected above (unless specified)

CBC and Baseline Iron Labs:

- | | |
|---|-------------------------------|
| <input checked="" type="checkbox"/> CBC | <input type="checkbox"/> Once |
| <input type="checkbox"/> Iron + TIBC | <input type="checkbox"/> Once |
| <input type="checkbox"/> Transferrin Saturation | <input type="checkbox"/> Once |
| <input type="checkbox"/> B12 | <input type="checkbox"/> Once |
| <input type="checkbox"/> Folate | <input type="checkbox"/> Once |
| <input type="checkbox"/> Ferritin (serum) | <input type="checkbox"/> Once |

Provider Communication:

- Nursing Communication Order will be done as per appointment frequency
If no iron studies resulted within the past 3 months, order Ferritin and Iron Saturation (TSAT)

Medications:

- Order will be done as per appointment frequency
- Darbepoetin, SubQ
- 25 mcg
 - 40 mcg
 - 60 mcg
 - 100 mcg

All information provided on this form & calculations have been independently confirmed & recalculated as indicated by signature(s) below

Licensed Medical Professional

Print Name: _____
Signature _____
Date _____
Contact # _____

Attending Physician

Print Name: _____
Signature _____
Date _____
Contact # _____

Name: _____
MRN: _____
DOB: _____

Indications:

- Chemotherapy-induced anemia
- Myelosuppressive chemotherapy
- Radiation therapy
- Other: _____
- Order will be done as per appointment frequency
- Anemia due to myelodysplastic syndrome
- Anemia in chronic kidney disease
- Anemia in hemodialysis-dependent chronic kidney disease

Emergency Medications

- Hypersensitivity reaction protocol
Protocol Document: <https://emory.ellucid.com/documents/view/15307/15641>

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Licensed Medical Professional

Attending Physician

Print Name: _____
Signature _____
Date _____
Contact # _____

Print Name: _____
Signature _____
Date _____
Contact # _____