

Name: _____
MRN: _____
DOB: _____

Today's Date _____ Time _____

Diagnosis: _____ 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 min
- Once
- Weekly
- Every 2 weeks
- SubQ three times weekly x _____ weeks.

Treatment Conditions (Administer Treatment if): Order will be done as per appointment frequency

- Chronic Kidney Disease: Hemoglobin < 10 g/dL
- 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)

- | | |
|---|--|
| <input checked="" type="checkbox"/> CBC | <input type="checkbox"/> Once on Day 1 |
| <input type="checkbox"/> Iron + TIBC | <input type="checkbox"/> Once on Day 1 |
| <input type="checkbox"/> Transferrin Saturation | <input type="checkbox"/> Once on Day 1 |
| <input type="checkbox"/> B12 | <input type="checkbox"/> Once on Day 1 |
| <input type="checkbox"/> Folate | <input type="checkbox"/> Once on Day 1 |
| <input type="checkbox"/> Ferritin (serum) | <input type="checkbox"/> Once on Day 1 |

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

Licensed Medical Professional

Attending Physician

Print Name: _____
Signature _____
Date _____
Contact # _____

Print Name: _____
Signature _____
Date _____
Contact # _____

Name: _____
MRN: _____
DOB: _____

Medications:

- Hypersensitivity Protocol
- Treatment time: use EHC default unless noted in order

Chronic Kidney Disease (CKD):

Epoetin alfa _____ Units (_____ Units/kg)

- Once
- Weekly
- Every 2 weeks
- SubQ three times weekly x _____ weeks.

- Usual starting dose is 50 – 100 Units/kg
- IV preferred for patients on dialysis
- Contact MD if:
 - Hemoglobin increases by more than 1 g/dL in the past two weeks
 - Hemoglobin \geq 10g/dL
 - Inadequate / lack of response over a 12 week escalation period. Consider discontinuing or use minimum effective dose that will maintain a hemoglobin level sufficient to avoid RBC transfusions.

Emergency Medications

Order will be done as per appointment frequency

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 _____
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Contact # _____