SHERIDAN COMMUNITY HOSPITAL
OUTPATIENT INFUSION CENTER
PHONE: 989.291.6295 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.