



**Procrit Order Form**

**DEMOGRAPHICS**

PatientName: \_\_\_\_\_ DateofBirth: \_\_\_\_\_ Gender:  F  M  
 Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 LegallyResponsibleRepresentative: \_\_\_\_\_ RelationshiptoPatient: \_\_\_\_\_

<b><u>Diagnoses:</u></b>	<input type="checkbox"/> CHRONIC KIDNEY DISEASE STAGE 1	<input type="checkbox"/> CHRONIC KIDNEY DISEASE STAGE 4
	<input type="checkbox"/> CHRONIC KIDNEY DISEASE STAGE 2	<input type="checkbox"/> CHRONIC KIDNEY DISEASE STAGE 5
	<input type="checkbox"/> CHRONIC KIDNEY DISEASE STAGE 3	<input type="checkbox"/> END STAGE RENAL DISEASE

**Medication Orders:**  
 Procrit \_\_\_\_\_ 2,000/4,000/10,000 units inject SQ every \_\_\_\_\_ 3xweek/week.  
 Duration: \_\_\_\_\_ 1 month/ 6 month/ 1 yr.

**Tried and Failed:**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Labs drawn on:**  
 HCT: \_\_\_\_\_ HGB: \_\_\_\_\_ TOTAL IRON: \_\_\_\_\_ TIBC/TRANSFERRIN: \_\_\_\_\_  
 UIBC: \_\_\_\_\_ % TRANSFERRIN SAT: \_\_\_\_\_ FERRITIN: \_\_\_\_\_

\_\_\_\_\_  
*PrescriberSignature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Please Print Name*

\_\_\_\_\_  
*NPI*