Wellspring Health
INFUSION CENTER

Aranesp Order Form

Patient Name: _____ **DOB:** _____

Address: _____

Phone: _____ **ICD-10 Diagnosis Code(s):** _____

Labs:

Hemoglobin and Hematocrit will be drawn at each appointment unless labs were recently done.

Other labs to be done _____

Frequency of other labs _____

Rx:

Aranesp Dose: _____mcg subcutaneous injection every (circle one) 1 2 4 6 8 week(s).

If Hgb greater than or equal to _____, hold Aranesp.

Dose Adjustments? (Circle one) Yes No

If yes:

If Aranesp held, repeat Hgb at next visit and restart at next lower commercially available dose if Hgb is less than hold parameter define above.

Order Duration:

☐ 1 year ☐ 6 months ☐ 3 months ☐ Other duration: _____

Please fax completed forms to 563-900-8290 or email them to info@wellspringhlth.com.

Prescriber: _____ **Date:** _____

Prescriber Signature: _____

Address: _____ **Phone:** _____ **Fax:** _____

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Fax: (563) 900-8290 **Call:** (563) 900-8300 **Email:** info@wellspringhlth.com