FAX BACK TO 951-530-4801 EMPIRE PHARMACY RIVERSIDE, CA PHONE 951-530-8800

Procrit Order Form

DEMOGRAPHICS

PatientName:_____ DateofBirth:_____ Gender:❑F❑M

Home Phone:_____ Cell:_____ Work:_____

Address:_____

City:_____ State:_____ Zip:_____

LegallyResponsibleRepresentative:_____ RelationshiptoPatient:_____

Diagnoses:	❑ CHRONIC KIDNEY DISEASE STAGE 1 ❑ CHRONIC KIDNEY DISEASE STAGE 2 ❑ CHRONIC KIDNEY DISEASE STAGE 3	❑ CHRONIC KIDNEY DISEASE STAGE 4 ❑ CHRONIC KIDNEY DISEASE STAGE 5 ❑ 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*