MIC | METRO INFUSION CENTER

# RBC Growth Factor Injection

Name: _____
DOB: _____
Diagnosis/Code: _____/_____

**Dose calculation:**
Flat dose, not a weight-based medication

**Laboratory or Other Tests Related to Chemotherapy:**
CBC pre dose to regulate for hemoglobin response

**Dosing Guidelines/ Parameters:**
☐ Hold for hemoglobin greater than 11
☐ Hold for hemoglobin greater than _____

**Hydration Orders:** ☐ Not Required

**Premedication and Antiemetic Orders:** ☐ Not Required

**Medication Orders:**

| DRUG | DOSE | ROUTE | DAYS TO BE GIVEN |
|---|---|---|---|
| ☐ Aranesp® (darbepoetin alfa) | _____mcg | SQ | Every _____week(s) |
| ☐ Procrit®/Epogen® (epoetin alfa) | _____units | SQ | Every _____ week(s) |
| ☐ Retacrit™ (epoetin alfa-epbx) | _____units | SQ | Every _____week(s) |
| ☐ | | | |

Day 1 = _____ then as per dosing schedule +/- 2 days

This order is good for 1 year from the date ordered

**Other:**

**Call referring provider for:**

Other reasons to call:

| DATE | Referring Provider:_____ _____ Telephone#_____ |
|---|---|
| | SIGNATURE REQUIRED PRINTED NAME REQUIRED |

**Send a referral via fax at 866-507-1164 or email to the bionurses@metroinfusioncenter.com**