

Patient Name:						Date of Birth:					
P.E.I. Health Card Number:						Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>					
Mailing Address:				City or Town:				Postal Code:			
Home Phone Number:				Work Phone Number:				Contact Name & Number:			

Referring Source: Nephrologist Office <input type="checkbox"/> CRIC <input type="checkbox"/> HDU <input type="checkbox"/> Transplant Clinic <input type="checkbox"/> Other <input type="checkbox"/>											
Referral Phone Number:						Referral Fax Number:					

<b>For the Treatment of Severe Anemia related to Chronic Renal Failure in Patient with:</b>											
<input type="checkbox"/> 1. Normocytic normochromie anemia, requiring transfusions in patients who have evidence of iron overload (Ferritin >1000 ng/ml).											
<input type="checkbox"/> 2. Anemia requiring blood transfusions in patients having symptomatic angina and/or heart failure.											
<input type="checkbox"/> 3. Anemia requiring transfusions in patients with difficulties in blood grouping and febrile reactions due to antibodies.											
<input type="checkbox"/> 4. Anemia requiring transfusions in patients who have high levels of panel reactive anti HLA antibodies.											
<input type="checkbox"/> 5. Patients with severe normocytic normochromic anemia (Hb <100g/l) whose only symptoms is fatigue and have never received transfusions											

Serum Ferritin Level:						Hb Level:					
Drug Requested: Eprex™ (Epoetin Alpha) <input type="checkbox"/>						Aranesp™ (Darbepoetin Alfa) <input type="checkbox"/>					
Specify dosage, route, and frequency:											

Nephrologist's Name:				Nephrologist's Signature:				Date:			
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Prescription Given to Patient? Yes <input type="checkbox"/> No <input type="checkbox"/>						Administration Will Be By: Self <input type="checkbox"/> Home Care <input type="checkbox"/> Other <input type="checkbox"/>					
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Name of PEI Family Physician:											
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Fax or mail completed form to:						Erythropoietin Program PEI Pharmacare 16 Fitzroy Street, Box 2000 Charlottetown, PE C1A 7N8 Fax: 902-368-4905					
Prescription to be filled at:						QEH <input type="checkbox"/> PCH <input type="checkbox"/> Other <input type="checkbox"/>					
Notification: Patient <input type="checkbox"/> PEI Physician <input type="checkbox"/> Referring Source <input type="checkbox"/> Hospital Pharmacy <input type="checkbox"/> Dialysis Unit <input type="checkbox"/> Home Care <input type="checkbox"/>											