ORANGE REGIONAL MEDICAL CENTER

Informed Consent for Infusion Center Treatment

PATIENT
Hosdaghian, Yeghiche

I hereby give my consent and authorize: Dr. Ramaswamy and those who he/she may designate as associates or assistants and Orange Regional Medical Center (Hospital) and its staff to perform the following

treatment upon: HOSDAGHIAN, YEGHICHE
(Patient's name):

(Describe the treatment in both clinical and laymen's terms. No Acronyms or Abbreviations):

Avastin 40mg Subcut weekly
for dizziness

I give permission with full knowledge and understanding thereof. I understand that medicine is not an exact science and that there is the possibility that the treatment may not have the benefits or results intended. I am also aware that there are always risks and dangers to life and health associated generally with the, use of medication, and treatments which can cause adverse consequences not ordinarily anticipated in advance, but I give this permission with full assent nevertheless.

By signing below, I confirm that I fully understand the information provided to me, my questions have been answered, and I give my consent to the treatment(s) specified above.

(Patient/Health Care Agent/Surrogate/Guardian Signature)	(Printed Name)	(Relationship to Patient)	(Date)	(Time) AM PM
			/ /	
(Witness Signature)	(Printed Name)		(Date)	(Time) AM PM
			/ /	

☐ Mark this box if telephone consent ☐ Mark this box if interpreter was involved.

I have discussed the nature and purpose and the reasonably foreseeable risks and benefits of the treatment(s), the alternatives, including not performing the treatment(s), as well as the risks and benefits of the alternatives; and I am satisfied that the patient or the patient's legal representative who signed above understands them.

12/7/17 / 1245pm

(Signature of Physician/Appropriately Credentialed Practitioner Providing Explanation) Date / Time

Risk Management/nsm/August 2012

ORANGE REGIONAL MEDICAL CENTER
Physician Order Form

HOSDAGHIAN, YEGHICHE
DOB 11/17/1940
Patient Label

DO NOT USE ABBREVIATIONS:

U	MS	MSO_4	$MgSO_4$	QD	µg
IU	SC	SQ	SL	QOD	

OUTPATIENT DARBEPOETIN (Aranesp®) Erythropoetic Stimulating Agent (ESA) Order Form

Initial Hemoglobin (Hgb)/Hematocrit (Hct) Date/level:_____ Wt: _____ kg
Current Hgb:_____ Hct: _____

DIAGNOSIS (Check one):

☐ Chemotherapy induced anemia
Hemoglobin (Hgb) / Hematocrit (Hct) must be < 10 g/dl and < 30%
Darbepoetin initial dose ≤ 2.25 mcg/kg/week
On week 4 doses may be increased by 25% if Hgb/Hct rise is < 1/3.
By week 8 discontinue treatment unless a rise of 1/3 is documented

☐ End Stage Renal Disease (ESRD) on dialysis

☒ Chronic Kidney Disease (CRD) not on dialysis
Hold Aranesp for Hgb ≥ 11 gms
For chronic kidney disease creatinine ≥ 3 and CrCl < 60 mL/min
Monitor to ensure transferring saturation > 20% and/or serum ferritin > 100 ng/mL

☐ HIV/AIDS anemia induced by zidovudine or other nucleoside reverse transcriptase inhibitors

☐ Anemia related to myelodysplastic syndrome (MDS) excluding AML and CML
Bone marrow biopsy < 5% blasts
Erythropoietin level 100 or less
After 2 months of treatment consider discontinuing if there is no significant increase in Hgb/Hct and/or decreased transfusions

☐ Treatment of anemia of selected chronic diseases
Rheumatoid arthritis, systemic lupus erythematosus, inflammatory bowel diseases, and hepatitis C undergoing treatment

Initial Hgb/Hct must be < 10 g/dl and < 30%. For all uses other than chemotherapy induced anemia titrate dose of darbepoetin to maintain a target Hgb of 10-12 g/dl and Hct of 30-36% by appropriate timed dose adjustment.

Date of last ESA agent: _____ Do not give Darbepoetin more frequently than once weekly

Drug	Dose (mcg)	Route	Frequency	RN/Time
Darbepoetin (Aranesp®)	40mcg	☒ SubQ ☐ IV	once a week	

Print Last Name RAMASWAMY
Physician Signature _____
Date 12/7/17 Time:_____

Print Last Name:_____
Nurse Signature:_____ Date:_____
RBV INIT___Time:_____ Faxed ☐ Time Faxed _____