Epogen/Procrit/Aranesp Consent
Oklahoma Kidney Care
13901 McAuley Blvd, Suite 303
Oklahoma City, OK 73134

Patient Name: ____

Patient DOB: ___________________________

Date:

I ____________________________________, do hereby request and authorize Dr. ___________________________to prescribe Epogen/Procrit/Aranesp.

I acknowledge that the benefit of receiving these medications is raising my red blood count (hemoglobin) to avoid blood transfusions. Blood transfusions will reduce my chance of receiving a kidney transplant and carry other risks.

I have read the patient information guide regarding these medications and my healthcare provider has discussed the risks.

I have been given the opportunity to proceed with or without this medicine.

I acknowledge that some of the common side effects of these drugs include, but are not limited to: joint, muscle or bone pain, fever, cough, rash, nausea and vomiting, soreness of mouth, itching, headache, and redness and pain in the skin where these drugs are given.

I acknowledge that some of the risks associated with use of these medications include, but are not limited to: heart attack, stroke, heart failure, blood clots, seizures, elevated blood pressure,cancer, or death.

I will inform my doctor immediately if I have been diagnosed with any of the above mentioned conditions

I will inform my doctor immediately if I have chest pain, trouble breathing, pain in my legs with or without swelling, cool or pale arm or leg, sudden confusion, trouble speaking, trouble understanding others' speech, sudden numbness or weakness in my face, arm or leg, especially on one side of my body, sudden

trouble seeing, sudden trouble walking, dizziness, loss of balance or coordination, or loss of consciousness.

I will inform my doctor immediately if I develop an allergic reaction to these drugs or have symptoms which include rash and itching, breathing difficulty, wheezing, dizziness, drop in blood pressure, swelling around the eyes or mouth, fast pulse or sweating.

I will inform my doctor immediately if I am pregnant, planning to become pregnant or am breastfeeding . These drugs can harm the unborn baby.

I will inform my doctor immediately if I miss a dose or take an extra dose.

I will inform my doctor immediately if I have surgery or plan to have surgery while on this medication or if I am hospitalized.

I agree to regular blood tests as ordered by my physician to monitor this medication.

Signed ______________________________ Date ______________________________

(Patient or person authorized to request for patient)

Relationship or capacity ____

Witness______________________________ Date ______________________________

I have explained the above mentioned drugs, alternatives and risks to the person(s) whose signature(s) are affixed above.

Physician's Signature______________________________ Date _________________