

Troy Infusion Center  
600 W Main Street  
Suite 120  
Troy, OH 45373  
Phone: 937-401-6620  
Fax: 937-401-6629



Washington Township Infusion Center  
1989 Miamisburg-Centerville Road  
Suite 101  
Dayton, OH, 45459  
Phone: 937-401-6620  
Fax: 937-401-6629

**Retacrit® / Procrit® Order Form**  
Epic Referral: REF115228

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **ICD-10 Diagnosis Code(s):** \_\_\_\_\_

**Labs:**

Hemoglobin and Hematocrit will be drawn at each appointment unless labs were recently done.

Other labs to be done \_\_\_\_\_

Frequency of other labs \_\_\_\_\_

**Rx:**

Retacrit or Procrit, either is fine       Retacrit only       Procrit only

Dose: \_\_\_\_\_ units subcutaneous injection every (circle one) 1 2 4 6 8 week(s).

If Hgb greater than or equal to \_\_\_\_\_, hold injection.

**\*\*If patient's current dose is held for more than 2 sequential encounters, office will be contacted for further direction regarding dose and frequency.\*\***

**Order Duration:**

1 year     6 months     3 months     Other duration: \_\_\_\_\_

Other Comments: \_\_\_\_\_

**Prescriber Printed Name:** \_\_\_\_\_

**Prescriber Full Address:** \_\_\_\_\_

**Office Phone Number:** \_\_\_\_\_ **Office Fax Number:** \_\_\_\_\_

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_