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

Hamilton Infusion Center
1010 Cereal Drive
Suite 300
Hamilton, OH, 45013
Phone: 855-500-2873
Fax: 513-867-4166

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:** _____