Patient Name:_____ **Date of Birth:** _____

Address: _____

Phone: _____ **ICD-10 Diagnosis:**_____

Rx:
☐ Retacrit or Procrit, either is fine ☐ Retacrit only ☐ Procrit only

Dose and Frequency:
☐ 10,000 units subcutaneously every 1 week
☐ 20,000 units subcutaneously every 2 weeks
☐ 30,000 units subcutaneously every 3 weeks
☐ 40,000 units subcutaneously every 4 weeks
☐ Other: _____ units subcutaneously every _____ weeks

If Hgb greater than or equal to 10g per dL 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.

Labs: will be drawn at each appointment or within 1 week
☐ Hemoglobin and Hematocrit
☐ CBC

Other labs to be done:_____

Frequency of other labs:_____

Order Duration: ☐ 3 months ☐ 6 months ☐ One year ☐ Other:_____

Other orders/comments:_____

Prescriber printed name: _____

Prescriber full address:_____

Office phone number:_____ **Office fax number:**_____

_____ _____ _____
Prescriber signature Date Time

Questions? Call (419) 591-3858. Please fax complete form to (419) 592-4004.

HENRY COUNTY HOSPITAL
1600 East Riverview Ave • Napoleon, Ohio 43545
(419) 592-4015

RETACRIT/PROCRIT ORDER FORM

ONC-74 040726