Holland Hospital

AMBULATORY TREATMENT UNIT

Name: ______________________

Visit Number: ______________________

Date of Birth: ______________________

Medical Record Number: ______________________

Epoetin alfa-epdx (Retacrit) Flow Sheet

Date	Dose Given	Hgb/Date Drawn	Hgb Trend (↑, ↓ or flat)	Ferritin (Should be greater than 100)	Transferrin Sat % (Should be greater than 30%)	Action Taken	Next Dose & Frequency		Signature
							Projected Dose	Date	
	units	Date:__________ g/dL		Date:__________ ng/mL	Date: __________ %	☐ MD Notified. See EHR for documentation	Units Every _____ wk(s)		
	units	Date:__________ g/dL		Date:__________ ng/mL	Date: __________ %	☐ MD Notified. See EHR for documentation	Units Every _____ wk(s)		
	units	Date:__________ g/dL		Date:__________ ng/mL	Date: __________ %	☐ MD Notified. See EHR for documentation	Units Every _____ wk(s)		
	units	Date:__________ g/dL		Date:__________ ng/mL	Date: __________ %	☐ MD Notified. See EHR for documentation	Units Every _____ wk(s)		
	units	Date:__________ g/dL		Date:__________ ng/mL	Date: __________ %	☐ MD Notified. See EHR for documentation	Units Every _____ wk(s)		
	units	Date:__________ g/dL		Date:__________ ng/mL	Date: __________ %	☐ MD Notified. See EHR for documentation	Units Every _____ wk(s)		
	units	Date:__________ g/dL		Date:__________ ng/mL	Date: __________ %	☐ MD Notified. See EHR for documentation	Units Every _____ wk(s)		
	units	Date:__________ g/dL		Date:__________ ng/mL	Date: __________ %	☐ MD Notified. See EHR for documentation	Units Every _____ wk(s)		

MEDICATION ORDER

Please check and enter order for Epoetin alfa-epbx (Retacrit) ______________________ units subcutaneously on ______________ (Date) Time ____________

VO/WO/VORB Physician Name: ______________________________ RN Signature: ______________________ Date: ____________

Pharmacy section to be completed on copy being sent