Sparrow
Herbert-Herman Cancer Center

Sparrow Infusion Center

Phone: (517) 364-9402
Fax: (517) 487-3148

Legal Patient Name:	**DOB:**	**Height:**	**Weight:**	**BSA:**
ICD 10 Diagnosis Code:	**Diagnosis:**			
Allergies:				

MUST Include with Order:
- ☐ History & Physical
- ☐ Medication list
- ☐ Completed Prior Authorization (if required)
- ☐ Patient Demographics & Insurance
- ☐ Consent **REQUIRED** if ordering Blood Products and/or Chemotherapy

***Sparrow Infusion Center is not responsible for drawing or monitoring labs required before/after treatment.**

MEDICATION ORDERS				
Name	**Dose**	**Route**	**Frequency**	**Duration**
	☐ ________ mcg ☐ ________ mg ☐ ________ gram ☐ __________	☐ IV ☐ IM ☐ SC ☐ PO	☐ Daily ☐ Weekly ☐ Monthly ☐ Every _____ Months ☐ PRN ☐ Other ____________	☐ Once ☐ One Year ☐ Other ____________________ ____________________________ ____________________________
	☐ ________ mcg ☐ ________ mg ☐ ________ gram ☐ __________	☐ IV ☐ IM ☐ SC ☐ PO	☐ Daily ☐ Weekly ☐ Monthly ☐ Every _____ Months ☐ PRN ☐ Other ____________	☐ Once ☐ One Year ☐ Other ____________________ ____________________________ ____________________________
	☐ ________ mcg ☐ ________ mg ☐ ________ gram ☐ __________	☐ IV ☐ IM ☐ SC ☐ PO	☐ Daily ☐ Weekly ☐ Monthly ☐ Every _____ Months ☐ PRN ☐ Other ____________	☐ Once ☐ One Year ☐ Other ____________________ ____________________________ ____________________________
	☐ ________ mcg ☐ ________ mg ☐ ________ gram ☐ __________	☐ IV ☐ IM ☐ SC ☐ PO	☐ Daily ☐ Weekly ☐ Monthly ☐ Every _____ Months ☐ PRN ☐ Other ____________	☐ Once ☐ One Year ☐ Other ____________________ ____________________________ ____________________________
	☐ ________ mcg ☐ ________ mg ☐ ________ gram ☐ __________	☐ IV ☐ IM ☐ SC ☐ PO	☐ Daily ☐ Weekly ☐ Monthly ☐ Every _____ Months ☐ PRN ☐ Other ____________	☐ Once ☐ One Year ☐ Other ____________________ ____________________________ ____________________________

CENTRAL LINE CARE

☐ Use existing central line (Sparrow Infusion Center flushes central lines with normal saline ONLY)

To order Heparin, check below:
- ☐ Heparin 500 units/ 5 ml per lumen
- ☐ Alteplase 2 mg IV PRN

Printed Provider Name:______________________________________**Office Phone:** _______________________

Provider Signature:_______________________________**Date:** ____________________**Time:**____________