Patient Name: ___________________ Ordering Physician: ___________________

**Nursing:**
- **Doctor have privileges?**
  - Y / N
  - If no, orders will be scanned to the Medical Director for approval

**Order checklist:**
- □ Patient: Legal Name & DOB
- □ Medication: Name / Dose / Unit / Frequency / Route / Duration
- □ Prescriber printed name / signature / date
- □ Diagnosis & CD10 code
- □ No white out
- □ Blood consent (if applicable, only for prbc/plts)
  - □ NA
- □ Labs (if applicable)
- □ H&P (if applicable, need if new pt/new med order)
  - □ NA
- Clarifications needed? Y / N

**Authorization:**
- Y / N Medical Director approval needed?
  - (If yes) Date scanned __________ Date approved ____________
- Y / N Insurance prior authorization included?
- Y / N Needed from referring physician’s office?
  - Date received __________
- Y / N Send for Medical Necessity Review? (Annie/Tammie/Shawn)
  - Date sent __________ Date approved ____________
- Y / N IVIG orders?
  - Date faxed to pharmacy (Amber) for approval __________
- Y / N Specialty Pharmacy medication?
  - Date referred to coordinate delivery (Karen Brown) ____________

**Scheduling:**
- Y / N Patient scheduled?
- Y / N Office aware?
- Y / N All information scanned?

**Notes:**
Sparrow Infusion Center

Call for Questions 517-364-9402  Fax forms to 517-487-3148

<table>
<thead>
<tr>
<th>Legal Patient Name:</th>
<th>DOB:</th>
<th>Ht:</th>
<th>Wt:</th>
<th>BSA:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis:</td>
<td>ICD 10 code:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Fax to 517-487-3148:  
- Current History & Physical & Medication list
- Results of any required labs if done at non-Sparrow facility
- Completed Prior Authorization (PA) (if required)
- Patient Demographics and Insurance Information

Duration of Order:  
- Once
- One Year
- Other __________________

### MEDICATION ORDERS

<table>
<thead>
<tr>
<th>Name</th>
<th>Check if premed</th>
<th>Dose</th>
<th>Unit</th>
<th>Route</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>mcg</td>
<td>IV</td>
<td>Daily</td>
<td>Every _ months</td>
</tr>
<tr>
<td></td>
<td></td>
<td>mg</td>
<td>IM</td>
<td>Weekly</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>gram</td>
<td>SC</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PO</td>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

- Authorization is granted to supply by non-proprietary name as per formulary policy unless checked here.

### IV Access Care

- Use existing central venous access
- Infusion Center flushes all lines with saline only.
- To order Heparin, please check below:
  - Heparin _____ units/ml _____ units per lumen PRN
  - Alteplase 2 mg IV PRN

### LAB ORDERS

<table>
<thead>
<tr>
<th>Name</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Printed Provider Name: ____________________  Office Phone: ____________________

Provider Signature: ________________________  Date: ________________________