

Legal Patient Name:	DOB:	Height:	Weight:	BSA:
ICD 10 Diagnosis Code:		Diagnosis:		
Allergies:				
<input type="checkbox"/> History & Physical <input type="checkbox"/> Medication List MUST Include with Order: <input type="checkbox"/> Completed Prior Authorization (if required) <input type="checkbox"/> Patient Demographics & Insurance <input type="checkbox"/> 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
	<input type="checkbox"/> _____ mcg <input type="checkbox"/> _____ mg <input type="checkbox"/> _____ gram <input type="checkbox"/> _____	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> SC <input type="checkbox"/> PO	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every _____ Months <input type="checkbox"/> PRN <input type="checkbox"/> Other _____	<input type="checkbox"/> Once <input type="checkbox"/> One Year <input type="checkbox"/> Other _____ _____ _____
	<input type="checkbox"/> _____ mcg <input type="checkbox"/> _____ mg <input type="checkbox"/> _____ gram <input type="checkbox"/> _____	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> SC <input type="checkbox"/> PO	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every _____ Months <input type="checkbox"/> PRN <input type="checkbox"/> Other _____	<input type="checkbox"/> Once <input type="checkbox"/> One Year <input type="checkbox"/> Other _____ _____ _____
	<input type="checkbox"/> _____ mcg <input type="checkbox"/> _____ mg <input type="checkbox"/> _____ gram <input type="checkbox"/> _____	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> SC <input type="checkbox"/> PO	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every _____ Months <input type="checkbox"/> PRN <input type="checkbox"/> Other _____	<input type="checkbox"/> Once <input type="checkbox"/> One Year <input type="checkbox"/> Other _____ _____ _____
	<input type="checkbox"/> _____ mcg <input type="checkbox"/> _____ mg <input type="checkbox"/> _____ gram <input type="checkbox"/> _____	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> SC <input type="checkbox"/> PO	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every _____ Months <input type="checkbox"/> PRN <input type="checkbox"/> Other _____	<input type="checkbox"/> Once <input type="checkbox"/> One Year <input type="checkbox"/> Other _____ _____ _____
	<input type="checkbox"/> _____ mcg <input type="checkbox"/> _____ mg <input type="checkbox"/> _____ gram <input type="checkbox"/> _____	<input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> SC <input type="checkbox"/> PO	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every _____ Months <input type="checkbox"/> PRN <input type="checkbox"/> Other _____	<input type="checkbox"/> Once <input type="checkbox"/> One Year <input type="checkbox"/> Other _____ _____ _____

CENTRAL LINE CARE
<input type="checkbox"/> Use existing central line (Sparrow Infusion Center flushes central lines with normal saline ONLY) <input type="checkbox"/> Perform central line care per Sparrow Hospital policy & procedure
To order Heparin, check below: <input type="checkbox"/> FOR PORT: Heparin 500 units/ 5 ml per lumen <input type="checkbox"/> FOR PICC: Heparin 250 units/ 2.5 ml per lumen <input type="checkbox"/> Alteplase 2 mg IV PRN

Printed Provider Name: _____ Office Phone: _____

Provider Signature: _____ Date: _____ Time: _____