Corewell Health™

Patient Name	
DOB	
MRN	
Physician	
CSN	

Physician's Orders
HYDRATION WITH OPTIONAL ANTIEMETICS - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER

Corewell Health Site of Service (select one):

☐ **Blodgett Hospital**
1840 Wealthy St. SE
Grand Rapids, MI 49506
Phone: 616.391.0351
Fax: 616.391.8969

☐ **Gerber Hospital**
230 West Oak St.
Fremont, MI 49412
Phone: 231.924.1305
Fax: 231.924.1798

☐ **Greenville Hospital**
615 S. Bower St.
Greenville, MI 48838
Phone: 616.225.9330
Fax: 616.754.4043

☐ **Helen DeVos Children's Hospital**
35 Michigan St. NE Floor 2
Grand Rapids, MI 49503
Phone: 616.267.1925
Fax: 616.267.1005

☐ **Lemmen Holton Cancer Pavilion**
145 Michigan St. NE Ste 5200
Grand Rapids, MI 49503
Phone: 616.486.6099
Fax: 616.486.6415

☐ **Ludington Hospital**
1 Atkinson Dr.
Ludington, MI 49431
Phone: 231.845.5085
Fax: 231.845.5025

☐ **Neuro Infusion ICCB**
2750 E Beltline Ave. NE
Grand Rapids, MI 49525
Phone: 616.391.0351
Fax: 616.391.8969

☐ **Pennock Hospital**
1009 W Green St.
Hastings, MI 49058
Phone: 269.798.6762
Fax: 269.798.6763

☐ **Reed City Hospital**
4499 S 220th Ave.
Reed City, MI 49677
Phone: 231.832.7105
Fax: 231.832.0195

☐ **Zeeland Hospital**
8333 Felch St.
Zeeland, MI 49464
Phone: 616.748.3640
Fax: 616.748.3690

☐ **Brownstown Infusion Clinic**
19725 Allen Rd. Ste 101
Brownstown Twp, MI 48183
Phone: 734.479.2371
Fax: 734.479.2451

☐ **Dearborn Hospital**
18101 Oakwood Blvd.
Dearborn, MI 48124
Phone: 313.593.5913
Fax: 313.593.5802

☐ **Farmington Hills Hospital Botsford**
28050 Grand River Ave.
Farmington Hills, MI 48336
Phone: 947.521.8174
Fax: 248.471.8217

☐ **Grosse Pointe Infusion Clinic**
21400 E 11 Mile Rd.
Saint Clair Shores, MI 48081
Phone: 586.498.4498
Fax: 586.498.4497

☐ **Lenox Infusion Clinic**
36555 26 Mile Rd. Ste 3300
Lenox, MI 48048
Phone: 947.523.4060
Fax: 947.523.4061

☐ **Livonia Infusion Clinic**
39000 W 7 Mile Rd. Ste 3000
Livonia, MI 48152
Phone: 947.523.4360
Fax: 734.542.3356

☐ **Royal Oak**
3601 W 13 Mile Rd.
Royal Oak, MI 48073
Phone: 248.898.1000
Fax: 248.551.3168

☐ **Troy Hospital**
44344 Dequindre Rd. Ste 230
Sterling Heights, MI 48314
Phone: 248.964.3080
Fax: 248.964.2409

☐ **Wayne Hospital**
33155 Annapolis St.
Wayne, MI 48184
Phone: 734.467.2556
Fax: 734.467.2505

☐ **Marie Yeager Cancer Center**
3900 Hollywood Rd.
Saint Joseph, MI 49085
Phone: 269.556.7180
Fax: 269.556.7185

☐ **Niles Infusion**
42 N St. Joseph Ave. Ste 303
Niles, MI 49120
Phone: 269.684.6140
Fax: 269.683.8744

☐ **Watervliet Hospital**
400 Medical Park Dr.
Watervliet, MI 49098
Phone: 269.463.2310
Fax: 269.463.0012

PATIENT INFORMATION:

Name: First _____ Middle _____ Last _____

Date of birth _____ Phone (_____) _____

Address _____

City _____ State _____ Zip code _____

REFERRAL: Infusion Therapy

Referring Physician (print) _____

Office: Phone (_____) _____ Fax (_____) _____

Direct line for urgent questions about patient (_____) _____

CONTINUED ON PAGE 2 ➔

NOTE: Epic Treatment/Therapy Plan Orders. To be scanned/attached to the appropriate Infusion Referral Order in Epic.

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

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Physician's Orders
HYDRATION WITH OPTIONAL ANTIEMETICS - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER *(CONTINUED)*

Infusions:

Anticipated Infusion Date: _____ **ICD-10 Code with Description:** _____

Height _____ (cm) Weight _____ (kg) Allergies _____

Frequency:
☐ Once
☐ Every _____ days
☐ PRN every _____ days

Duration:
☐ Until Date: _____
☐_____# of Treatments
☐ 1 Year

Labs to be collected:

☐ Lab order(s) _____
- ☐ Once
- ☐ Every _____ days

Hydration:

☐ Sodium chloride 0.9% 1000 mL, IV, Administer over 60 minutes
☐ Lactated ringers 1000 mL, IV, Administer over 60 minutes
☐ Dextrose 5% and lactated ringers 1000 mL, IV, Administer over 60 minutes

☐ _____ _____ mL, IV, Administer over _____ minutes
(Base solution)

Electrolyte replacement
☐ Potassium chloride IV 20 mEq/100 mL for _____ doses

☐ Calcium gluconate IV
- ☐ 1 g/50 mL for _____ doses
- ☐ 2 g/100 mL for _____ doses

☐ Magnesium sulfate IV
- ☐ 2 g/50 mL for _____ doses
- ☐ 4 g/50 mL for _____ doses

Antiemetic therapy:

☐ Ondansetron (ZOFRAN) IV
- ☐ 4 mg
- ☐ 8 mg

☐ Prochlorperazine (COMPAZINE) 10 mg IV
Administer over 2 minutes

☐ Dexamethasone (DECADRON) 8 mg IV
Administer over 5 minutes

Medications:

☐ Thiamine (VITAMIN B1) 100 mg IV
Administer over 30 minutes

☐ Folic acid 1 mg IV
Administer over 30 minutes

☐ Medication with dose _____

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CONTINUED ON PAGE 3 ➔

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Supplemental Orders

*****The following orders will be applied to the patient's plan unless otherwise indicated*****

Appointment Requests

☒ **Infusion Appointment Request**
Status: Future, Expected: S, Expires: S+365, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after infusion

Nursing Orders

☒ **ONC NURSING COMMUNICATION 100**
May Initiate IV Catheter Patency Adult Protocol

☒ **Hypersensitivity Reaction Adult Oncology Protocol**
Until discontinued Starting when released Until Specified

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Telephone order/Verbal order documented and read-back completed. Practitioner's initials _____

NOTE: Unless Order is written DAW (dispense as written), medication may be supplied which is a generic equivalent by nonproprietary name.

TRANSCRIBED:		**VALIDATED:**		**ORDERED:**		
TIME	**DATE**	**TIME**	**DATE**	**TIME**	**DATE**	Pager #
	Sign		**R.N. Sign**		**Physician Print**	**Physician Sign**

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