Corewell Health™

Referral
INFUSION THERAPY - COREWELL HEALTH INFUSION SERVICES

Patient Name

DOB

MRN

Physician

CSN

COREWELL HEALTH LOCATION PATIENT WILL RECEIVE INFUSION THERAPY: ***(Check one)***

☐ **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**
Hematology Oncology
100 Michigan St. NE
Grand Rapids, MI 49503
Phone: 616.267.1925
Fax: 616.267.1005

☐ **Lemmen Holton Cancer Pavilion**
145 Michigan St. NE
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

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

☐ **Reed City Hospital**
4499 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

PATIENT INFORMATION:

Name: First _____ Middle _____ Last _____

Date of birth _____ Phone (_____) _____

Address _____

City _____ State _____ Zip code _____

Insurance(s) _____

Contract number(s) _____ Authorization number _____

Primary diagnosis: ICD-10 code _____ Description _____

Additional diagnosis(es): ICD-10 code _____ Description _____

ICD-10 code _____ Description _____

ICD-10 code _____ Description _____

REFERRAL:

☒ Infusion Therapy

TIME _____ **DATE** _____ Referring Physician signature _____

Referring Physician (print) _____

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

Direct line for urgent questions about patient (_____) _____

REFERRAL INSTRUCTIONS:

- **Complete, print** and **sign** this Referral.
- **Combine** this required information (below):
  - This Referral
  - The specific infusion medication order form. Get at: corewellhealth.org > For Health Care Professionals > Infusion Services Orders > under "Infusion Order Forms", choose the medication being ordered for infusion
  - Appropriate Laboratory study results needed for medication administration
  - Current History and Physical, Medication List, ***AND*** Allergies (If not available electronically to Corewell Health)
  - A facesheet
  - Consent(s) (if required). Get at: corewellhealth.org > For Health Care Professionals > Infusion Services Orders > just above "Infusion Order Forms" list, click on the consent(s) needed. Have patient sign
- **Verify information is legible** on ALL forms above.
- **Fax** the combined information to the location checked above.
- **If questions or concerns, call** the office of the location checked above.

FOR COREWELL HEALTH INFUSION SERVICES OFFICE USE ONLY

FAX RECEIVED: Date _____ Time _____

REFERRAL REVIEWED: ☐ Additional information needed ☐ Complete. Sent to Registered Nurse: Date _____ Time _____

Staff name (print) _____

DO NOT MARK BELOW THIS LINE — BARCODE ZONE — DO NOT MARK BELOW THIS LINE

X257229

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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