Spectrum Health

Referral
INFUSION THERAPY

Patient Name

DOB

MRN

Physician

FIN

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

☐ **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
Closed Friday

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

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

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

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: spectrumhealth.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 Spectrum Health)
  - A facesheet
  - Consent(s) (if required). Get at: spectrumhealth.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 SPECTRUM 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

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X25729 (10/22)