SPECTRUM HEALTH
Zeeland Community Hospital

Patient Label

IMPRINTED ORDERS for
Ambulatory Treatment – Single Visit Outpatient/Serial Visit

PATIENT INFORMATION (All sections MUST be completed prior to any visits scheduled)						
Last Name	**First Name**	**Initial**	**Sex** M F	**Age**	**DOB** ____/____/____	**Last 4 digits of SS#** ___ ___ ___ ___
Address	**City**	**State**	**ZIP**	**Cell Phone #**	**Home Phone #**	
Financially Responsible Party	**Date of Birth** ____/____/____	**Last 4 digits of SS#** ___ ___ ___ ___	**Insurance Name**	**Contract #**	**Group #**	
Diagnosis			**ICD 10: (*Required*)**			
Allergies			**Height**	**Weight**		

Information Required:

- ☐ **H&P/Office visit must be provided**
- ☐ **Current Medication List must be provided**

****PREAUTHORIZATION: All visits MUST be preauthorized with the patient's insurance provider.**
Authorization Number: _____ Limitations: _____

ORDERS

Start Date: _____/_____/_____
Stop Date: _____/_____/_____ (an order for 1 calendar year is dated from Start: 01/01/2017 to Stop: 12/31/2017)

MEDICATION	DOSE	ROUTE	FREQUENCY	PURPOSE	CHARGE ESTIMATE

TREATMENT(S):	

☐ Topical Anesthetic "pain ease" spray
- Initiate IV catheter patency protocol
- PICC line flush 10 ml per policy and PRN
- Port-A-Cath flushes heparinized saline 5 ml per policy and PRN

DISCHARGE PLAN

❑ Follow Up w/_____ next appoint Date:_____/____/____ Time: _____;_____ AM/PM
Other: _____

ORDER AUTHENTICATION

Ordering Physician Sig: _____ Date: _____ Time: _____

SHZCH Credentialed Physician Sig: _____Date: _____ Time: _____
(Co-Signature only necessary if ordering physician is not credentialed at SHZCH)

Fax to Ambulatory Treatment @ 616.748.3631 Questions? Call AARN Office @ 616.748.3640

For SHZCH Use Only
AARN: Call Business Office 866.703.2452 if no insurance or preauthorization code
BO: ☐ Approved ☐ Denied Rep _____ Date: _____ Time:_____
BO: Fax to AARN #83631 after approval determined. AARN notify physician office if denied