



**Spectrum Health**

**Referral  
INFUSION THERAPY**

Patient Name  
DOB  
MRN  
Physician  
FIN



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

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> <b>Gerber Hospital</b><br>230 West Oak St.<br>Fremont, MI 49412<br>Phone: 231.924.1305<br>Fax: 231.924.1798                     | <input type="checkbox"/> <b>Helen DeVos Children's Hospital</b><br>Hematology Oncology<br>100 Michigan St. NE<br>Grand Rapids, MI 49503<br>Phone: 616.267.1925<br>Fax: 616.267.1005 | <input type="checkbox"/> <b>Lemmen Holton<br/>Cancer Pavilion</b><br>145 Michigan St. NE<br>Grand Rapids, MI 49503<br>Phone: 616.486.6099<br>Fax: 616.486.6415 | <input type="checkbox"/> <b>Ludington Hospital*</b><br>1 Atkinson Dr.<br>Ludington, MI 49431<br>Phone: 231.845.2120<br>Fax: 231.845.2499                |
| <input type="checkbox"/> <b>Pennock Hospital</b><br>1009 W. Green St.<br>Hastings, MI 49058<br>Phone: 269.798.6762<br>Fax: 269.798.6763<br>Closed Friday | <input type="checkbox"/> <b>Reed City Hospital</b><br>4499 220th Ave.<br>Reed City, MI 49677<br>Phone: 231.832.7105<br>Fax: 231.832.0195  | <input type="checkbox"/> <b>United Memorial Hospital</b><br>615 S. Bower St.<br>Greenville, MI 48838<br>Phone: 616.225.9330<br>Fax: 616.754.4043               | <input type="checkbox"/> <b>Zeeland Hospital</b><br>8333 Felch St.<br>Zeeland, MI 49464<br>Phone: 616.748.3640<br>Fax: 616.748.3690<br>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](http://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](http://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) \_\_\_\_\_



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.



DO NOT MARK BELOW THIS LINE

BARCODE ZONE

DO NOT MARK BELOW THIS LINE



\* X 2 5 7 2 9 \*