POPS Sparrow Infusion Center
E. W. Sparrow Hospital
Phone: (517) 364-4412
Fax: (517) 374-6651

Legal Patient Name:	DOB:	Height:	Weight:	BSA:
ICD 10 Diagnosis Code:	Diagnosis:			
Allergies:				

MUST Include with Order:
- ☐ History & Physical
- ☐ Medication List
- ☐ Completed Prior Authorization (if required)
- ☐ Patient Demographics & Insurance
- ☐ Consent **REQUIRED** if ordering Blood Products and/or Chemotherapy

MEDICATION ORDERS				
Name	**Dose**	**Route**	**Frequency**	**Duration**
	☐ _________ mcg ☐ _________ mg ☐ _________ gram ☐ ____________	☐ IV ☐ IM ☐ SC ☐ PO	☐ Daily ☐ Weekly ☐ Monthly ☐ Every _____ Months ☐ PRN ☐ Other _____________	☐ Once ☐ One Year ☐ Other ____________________ __________________________ __________________________ __________________________
	☐ _________ mcg ☐ _________ mg ☐ _________ gram ☐ ____________	☐ IV ☐ IM ☐ SC ☐ PO	☐ Daily ☐ Weekly ☐ Monthly ☐ Every _____ Months ☐ PRN ☐ Other _____________	☐ Once ☐ One Year ☐ Other ____________________ __________________________ __________________________ __________________________
	☐ _________ mcg ☐ _________ mg ☐ _________ gram ☐ ____________	☐ IV ☐ IM ☐ SC ☐ PO	☐ Daily ☐ Weekly ☐ Monthly ☐ Every _____ Months ☐ PRN ☐ Other _____________	☐ Once ☐ One Year ☐ Other ____________________ __________________________ __________________________ __________________________
	☐ _________ mcg ☐ _________ mg ☐ _________ gram ☐ ____________	☐ IV ☐ IM ☐ SC ☐ PO	☐ Daily ☐ Weekly ☐ Monthly ☐ Every _____ Months ☐ PRN ☐ Other _____________	☐ Once ☐ One Year ☐ Other ____________________ __________________________ __________________________ __________________________
	☐ _________ mcg ☐ _________ mg ☐ _________ gram ☐ ____________	☐ IV ☐ IM ☐ SC ☐ PO	☐ Daily ☐ Weekly ☐ Monthly ☐ Every _____ Months ☐ PRN ☐ Other _____________	☐ Once ☐ One Year ☐ Other ____________________ __________________________ __________________________ __________________________

CENTRAL LINE CARE

To order Heparin, check below:
- ☐ FOR PORT: Heparin > 20 kg / 500 units / 5 ml < 20 kg 300 units / 3 ml
- ☐ FOR PICC: Heparin 250 units/ 2.5 ml per lumen
- ☐ Alteplase 2 mg IV P RN

Printed Provider Name: ____**Office Phone:** _________________

Provider Signature: _______________________________________**Date:** ________________**Time:** ___________