UNIVERSITY OF MICHIGAN HEALTH-WEST
MICHIGAN MEDICINE
Infusion Center

Sending a Referral to University of Michigan Health West

Please follow the steps below to send a referral:

1. Review the Required Documentation Checklist below and include listed documents
2. Fill out all fillable fields on the digital form OR print and fill form out manually.
3. Fax completed order form with all required documentation to (616) 475-3118

Required Documentation Checklist

If we do not receive all documents below with your referral or receive an incomplete medication order form, the order will be returned to you. **It may take up to 14 business days for the patient's insurance company to approve or deny our authorization request.*

- ☐ Completed Medication Order Form
- ☐ Patient Demographics
- ☐ Current Medication List and H&P
- ☐ Recent Visit Notes
- ☐ Lab Results
- ☐ Patient's Insurance Card
- ☐ Existing Prior Authorization *(if applicable)*

For patients requiring enrollment in co-pay assistance, it is the responsibility of the ordering office to complete and submit enrollment.

The patient will be responsible for submitting an Explanation of Benefits (EOB) and an itemized bill (obtainable through UMH West customer service department) to the co-pay assistance plan.

Hydration, Electrolytes, Anti-Emetics
Order Form

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PATIENT INFORMATION Referral Status: ○ New Referral ○ Updated Order ○ Order Renewal

Date: Patient Name: DOB:

Allergies: Weight (kg): Height (cm):

Primary ICD-10 & Description (required): Secondary ICD-10: Tertiary ICD-10:

☐ (required) The patient's demographics, insurance, lab results, meds and recent visit notes are attached

The patient has an existing prior authorization: ○ Yes (please include) ○ No (UMH West to obtain)

PRESCRIBING OFFICE

Contact Name: Contact Phone Number:

Ordering Provider: Provider NPI:

Practice Name: Phone: Fax:

Practice Address:

LAB ORDERS

Collect: ☐ BMP ☐ CMP ☐ CBC w/o Diff ☐ Magnesium ☐ _____

Lab Frequency: ○ ONCE at first infusion ○ Every infusion ○

THERAPY ADMINISTRATION

IV Hydration:

☐ 0.9% Sodium Chloride
☐ Dextrose 5% with 0.9% Sodium Chloride
☐ Dextrose 5% with Lactated Ringers
☐ Lactated Ringers
☐ 0.9% Sodium Chloride with ☐ 20meq ☐ 40meq Potassium Chloride (in 1000mL)

Volume to be infused at each visit:
☐ 1000 mL
☐ 2000 mL
☐ _____mL

IV Medications/Additives | Please select total dose to be given at each visit:

☐ None
☐ Folic Acid _____ mg
☐ Thiamine _____ mg
☐ Magnesium Sulfate _____ gm
☐ Dexamethasone _____ mg
☐ Other: _____

Anti-Emetics
☐ Ondansetron (Zofran) _____ mg
☐ Prochlorperazine (Compazine) _____ mg

Frequency: ○ One infusion ○ Daily for _____ days ○ _____-_____ times a week ○ Every other day
○ Weekly ○ PRN ○ _____

Injections: ○ Vitamin B12 (cyanocobalamin) 1000mcg IM
Frequency: _____ Number of doses: _____

*Order expires 12 months from ordering date

_____ _____ _____

Provider Name (Print) Provider Signature Date

UM Health-West Infusion Center
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p **616.252.5202** | f **616.475.3118** | UofMHealthWest.org