Inpatient Chemotherapy Reservation Form

Please complete and email to: premierhealthinpatientchemo@premierhealth.com

Reason for Inpatient Admission: (Please ensure documentation is in patient's chart)
☐ Prolonged Marrow suppression (example: Leukemia induction)
☐ Aggressive regimen requiring frequent monitoring which cannot be done in outpatient setting or Infusion Center
☐ Chemo drugs with significant side effects requiring aggressive symptom management and cannot be managed in outpatient setting or Infusion Center
☐ Regimen requiring prolonged continuous infusion
☐ History of instability or electrolyte imbalances with previous chemo administration
☐ BiTE Therapy

Today's Date:		Today's Time:	
Patient Information:			
Name:		DOB:	
Diagnosis (ICD code):			
Admitting Physician:		Adm Physician Phone #:	
Admitting Physician Tax ID:		Adm Physician NPI:	
Please select requested Hospital			
☐ MVH 1073688354	☐ MVHS 1073688354	☐ AMC 1700950060	☐ UVMC 1184638942
Please select type of admission			
☐ INPATIENT non-urgent*		☐ INPATIENT urgent	
☐ BiTE Therapy OBSERVATION (OP administration)		☐ BiTE Therapy INPATIENT administration	
Please select bed type			
☐ Med-Surg		☐ Advanced Care	
***Schedule non-urgent admissions 7 days in advance to allow for pre-certification process or patient financial assistance**			
Planned Inpatient Admission Date and Time:			

Checklist: Please ensure the following are addressed and completed:	**Yes**	**No**
Beacon orders are completed AND signed by provider		
Consent form is completed and signed by the provider and patient (**REQUIRED** for Chemotherapy/Immunotherapy/Targeted Therapy)		
MUGA Scan Completed (if indicated)		
If an implanted port is required, port has already been placed or scheduled to be placed prior to admission		
Insurance Card is attached to this form		
Office notes have been completed and are in Epic (or attached)		

Office Location:	
Person Completing Form:	
Contact Phone Number:	Fax Number: