Local Infusion

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SOLU-MEDROL (METHYLPREDNISOLONE) ORDER FORM

PATIENT INFORMATION

Patient Name: ______________________ DOB: __________

Mobile Number: ______________________ Patient Weight: ______________________kg

Allergies: ______________________

❑ Patient has known difficult venous access. Comments:______________________

❑ New Start Therapy | ❑ Continuation of Therapy & Date of last dose (if applicable): ______________________

DIAGNOSIS (Provider must specify)

❑ Primary Diagnosis:______________________

❑ Secondary Diagnosis:______________________

PROVIDER INFORMATION

Provider Name (print name): ______________________ Provider NPI:__________

Signature: ______________________ Date: __________

Contact Name: ______________________ Phone: __________ Fax: __________

Email Address: ______________________

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO ❑ Famotidine 20 mg IV ❑ Methylprednisolone (Solu-Medrol) 125 mg IVP

❑ Benadryl 25mg PO ❑ Cetirizine (Zyrtec) 10 mg PO

❑ Other: ______________________ Dose: __________ Route: __________

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Solu-Medrol	__________ mg	IV	❑ Once ❑ __________

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: ______________________

FAX NUMBERS:

❒ CT: 203.433.0621
❒ FL: 904.877.9270
❒ MA: 413.296.8482
❒ MD: 240.224.8607
❒ ME: 207.407.7272
❒ NC: 919.984.8698
❒ NH: 603.217.5371
❒ NJ: 201.581.4521
❒ NY: 631.250.6020
❒ OH: 937.871.4594
❒ PA: 610.273.5998
❒ SC: 864.973.6279
❒ VA: 703.202.0499