



Physician-led - Patient-centered Infusion-care

Please fax completed form, insurance card, and clinical documentation to:

FAX: 410-220-2553

SOLUMEDROL ORDER

New Start **Maintenance: Last Dose Given** _____

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Allergies: _____ Height: _____ Weight: _____		

Indication:

DOSAGE ORDERS:

Up to 55 kg 260 mg (2 vials)

Greater than 55 kg to 85 kg 390 mg (3 vials)

Greater than 85 kg 520 mg (4 vials)

Other _____

PREMEDICATION ORDERS: *antihistamine and 100mg methylprednisolone are recommended in the PI*

Acetaminophen po: 1000mg 500mg 30 min prior to infusion.

Diphenhydramine: 25mg PO 50mg PO 25mg IVP 30 min prior to infusion. Other

Prescriber Name: Title:

NPI: _____ DEA: _____

Prescriber Signature: Date of Order:

Referrals will not be processed until we receive ALL the following:

- Face Sheet / Patient Demographics
- Insurance card(s) – copy of front & back
- Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes) Most Recent Labs (within last 4-8 weeks) – Required:
- CBC CMP Lipids TB Hep B Other: _____