SOLU-MEDROL®

(methylprednisolone sodium succinate)

Advanced Infusion Care Centers®

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____ Address: _____

Allergies ☐ See List ☐ NKDA City, State, Zip: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ in ☐ cm Email: _____

PRIMARY DIAGNOSIS

☐ ICD10 Code: _____

PRESCRIPTION

☐ SOLU-MEDROL (methylprednisolone sodium succinate) 1000 mg IV x _____ days

REQUIRED DOCUMENTATION

- Insurance Card
- H&P
- Patient Demographics
- Most recent labs
- Medication List

ANCILLARY ORDERS

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol.
(See aiscaregroup.com for detailed policy)

☐ Other: Please fax other adverse reaction orders if checking this box

PRE-MEDICATION ORDERS PROTOCOL

☐ Per infusion center protocol: No recommended pre-medications for this infusion.

☐ Provider Prescribed: _____

LINE CARE ORDERS

Start PIV/Access CVC

Flush device per Advanced Infusion Care Centers' protocol *(See aiscaregroup.com for detailed policy)*

☐ Other Flush Orders: Please fax other line care orders if checking this box

LAB ORDERS—PLEASE INCLUDE FREQUENCY

☐ Please list any labs to be drawn by the infusion clinic: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

NPI: _____ Fax: _____

Office Contact Person: _____ Email: _____

Prescriber Signature: _____ Date: _____

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

All trademarks are property of their respective owners.