Checklist for IV Solumedrol Referral

Patient Name: _____ **DOB:** _____ **Date:** _____

Referring Physician: _____**NPI:**_____

Office Contact/Title/Email: _____

Office Address: _____

Office Phone: _____ **Office Fax:** _____

Best contact number for physician in case of reaction: _____

Please return completed checklist and checklist items to initiate referral. Use this form as fax cover sheet.

- ❑ Patient demographic information
- ❑ Insurance information and copy of insurance card/s (front and back). *Include primary and secondary insurance
- ❑ Supporting clinical notes and office visits. Two notes preferred.
  - o Note should include discussion about Solumedrol
  - o Medication list and allergies
- ❑ Solumedrol Prescribing Order (see attached)

Fax all information to our Infusion Coordinator: 508-698-8671
Call with any questions: 781-551-5812 option 4

Visit our website: www.InfusionCenterNE.com
Email: info@infusioncenterNE.com

Prescribing Order: IV Solumedrol

Date of Order: _____

Patient Name: _____ **DOB:** _____ **M/F:** _____

Diagnosis (include ICD-10 code/s): _____

❑ **NKDA** **Allergies:** _____

Patient Weight: _____

Premedication:
❑ Acetaminophen 1000mg PO   ❑ Diphenhydramine 25mg IV
❑ Loratadine 10mg or Cetirizine 10mg PO   ❑ Other: _____
❑ Diphenhydramine 25mg PO

Lab Orders:
❑ _____

Solumedrol Medication Order

❑ Solu-Medrol 1gm in 250ml NS IV over 60-90 min once a month x ____ months

❑ Solu-Medrol 1gm in 250ml NS IV over 60-90 min daily x 3 days

❑ Solu-Medrol 1gm in 250ml NS IV over 60-90 min daily x 5 days

❑ Solu-Medrol _____mg in _____ ml NS IV over _____ min x _____

Administration:
✓ Record vital signs pre-infusion and post-infusion, and PRN
✓ Mix, dilute, and administer steroid product per manufacturer guidelines.
✓ Do not administer if patient has active signs or symptoms of infection.
✓ In case of infusion reaction, STOP infusion and follow ICNE infusion reaction protocol. Notify physician.

_____   _____
Ordering Provider Name   **NPI**

_____   _____
Signature   **Date**