



134 Prince Avenue, Suite B
 Bellingham, WA 98226
 Phone (360) 933-4892
 Fax (360) 933-1197

Patient Name: _____

Date of Birth: _____ Weight: _____

IV Access: _____

Allergies: _____

Methylprednisolone (Solu-Medrol) Order Form

◆ Orders are initiated unless crossed out by provider.

Check box to initiate orders.

Please complete this form and fax to (360)933-1197. Call our office and our clinical pharmacists will be happy to make therapy recommendations.

Diagnoses:

Multiple Sclerosis

ICD-9: 340

_____ ICD-9: _____

_____ ICD-9: _____

Medication Orders:

Solu-Medrol 1 gram IV every 24 hours for 3 days

Solu-Medrol _____ IV every _____ for _____

Other: _____

◆ Alteplase 2mg IV to declot central IV access per Infusion Solutions protocol as needed for occlusion.

◆ Flush line with D5W, 0.9% NaCl and/or Heparin 10 units/ml or 100 units/ml per Infusion Solutions protocol.

◆ Infusion Reaction Management per Infusion Solutions protocol as needed.

Nursing Orders:

If no central IV access, RN to insert peripheral IV and rotate site every 72 to 120 hours or as needed.

Other: _____

Labs:

_____ weekly every _____

_____ weekly every _____

_____ weekly every _____

Prescriber Signature

Date

Please Print Name