



477 W. Horton Rd.
Bellingham, WA 98226
Phone (360) 933-4892
Fax (360) 933-1197

Patient Name: _____

Date of Birth: _____ Weight: _____

IV Access: _____ Height: _____

Allergies: _____

Methylprednisolone (Solu-Medrol) Order Form

Please fax this form, copies of insurance cards, demographics, and supporting clinical documentation to
(360) 933-1197 to facilitate an efficient referral. Thank you for choosing Infusion Solutions!

Diagnoses:

- | | |
|---|----------------|
| <input type="checkbox"/> Multiple Sclerosis, Relapsing remitting | ICD-10: G35 |
| <input type="checkbox"/> Multiple Sclerosis, Active primary progressive | ICD-10: G35.B1 |
| <input type="checkbox"/> Multiple Sclerosis, Active secondary progressive | ICD-10: G35.C1 |
| <input type="checkbox"/> Multiple Sclerosis, Unspecified | ICD-10: G35.D |
| _____ | ICD-10: _____ |
| _____ | ICD-10: _____ |

Medication Orders:

- ☐ Methylprednisolone 1 gram IV every 24 hours for 3 days
- ☐ Methylprednisolone _____ IV every _____ for _____
- ☐ Other: _____
- ◆ Alteplase 2mg IV to declot central IV access per Infusion Solutions protocol as needed for occlusion.
- ◆ Flush line with 0.9% NaCl, D5W and/or Heparin 10 units/ml or 100 units/ml per Infusion Solutions protocol.
- ◆ Lidocaine 1% - up to 0.2ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).
- ◆ Infusion Reaction Management per Infusion Solutions protocol as needed.

Nursing Orders:

- ◆ If no central IV access, RN to insert peripheral IV, rotate site as needed, and remove at end of therapy.
- ☐ Other: _____
- _____

Lab Orders:

- ☐ _____
- ☐ _____
- ☐ _____

Prescriber Signature

Date

Please Print Name

KEY: ◆ Orders are initiated unless crossed out by provider.

☐ Check box to initiate order.