



Methylprednisolone Patient Referral and Prescription Sheet

Return Signed RX via Fax to 800-915-3423

To: Greg Kratz, Pharm.D		From:	Phone:
Intake phone: 800-383-8393		Fax:	Number of Pages, Including Cover:
Date:	DOB:	Allergies:	
Patient Name:		Height:	Weight:
Medication Order:			
Methylprednisolone 1gm in 100mL 0.9% Sodium Chloride infused once daily over 1 hour via homepump -100mL/hr.			
Duration: x _____ days; last dose on _____; then discontinue above order and discharge patient.			
Has patient received above medication previously: Yes / No			
Standard Anaphylaxis Protocol required: No / Yes – Anaphylaxis kit = RX# _____			
Intravenous Access: PERIPHERAL			
Flush orders = protocol:			
RX# _____ 0.9% Sodium Chloride Flush: 3mL before and after each infusion and PRN			
RX# _____ Heparin 10units/ml 3ml after last saline each infusion			
Laboratory Orders: _____			

Diagnosis: _____		Chronic Conditions: _____	
Allergies: _____		_____	
_____		_____	
Date of Birth:		Height:	Weight:
Nursing Coverage: _____		Faxed	Communicated
Please fax the following information:			
<input checked="" type="checkbox"/> Methylprednisolone order – include dose, route of administration, frequency, duration, and any premedications OR use Rx order section above			
<input checked="" type="checkbox"/> Patient demographics – include insurance information. We will obtain authorization unless the insurance dictates otherwise			
<input checked="" type="checkbox"/> H & P OR progress note(s) describing diagnosis and clinical status			
<input checked="" type="checkbox"/> Labs – BUN/Creatinine (preferred within last 90 days)			
Orders Received via : Faxed Prescription from MD _____			
By: _____ MD Signature			
<small>CONFIDENTIALITY NOTICE</small>			
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