KabaFusion NJ
Patient-Focused Infusion Therapy

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:

☒ Methylprednisolone order – include dose, route of administration, frequency, duration, and any premedications **OR** use Rx order section above

☒ Patient demographics – include insurance information. **We will obtain authorization** unless the insurance dictates otherwise

☒ H & P **OR** progress note(s) describing diagnosis and clinical status

☒ Labs – BUN/Creatinine (preferred within last 90 days)

Orders Received via: : ☐ Faxed Prescription from MD _____

By: _____ MD Signature

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