



Methylprednisolone Patient Referral and Prescription Sheet Return Signed RX via Fax to 773.775.2732

To: David Kroc, Pharm.D		From:		Phone:	
Intake phone: 800.831.7740		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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