

SOLU-MEDROL

Please include the following to expedite the order:
Patient Demographics, Insurance Information, Labs

PATIENT

Referral Status: ☐ New ☐ Updated ☐ Renewal

Name: _____ DOB: _____ Gender: ☐ M ☐ F ☐ Other _____
Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

PRESCRIBER

Prescriber Name: _____ DEA: _____ NPI: _____ State License: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

CLINICAL

Diagnosis: ☐ ICD-10: _____ Indication: _____
Allergies: _____ Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in

TREATMENT

Solu-Medrol (methylprednisolone sodium succinate)

Route: Intravenous infusion

Dose: ☐ 500mg
☐ 1000mg
☐ Other: _____

Dilute in:

☐ 100ml NS
☐ 250ml NS
☐ Other: _____
☐ Per Restore Health Protocol

Frequency:

☐ Once daily for _____ days
☐ Other: _____

☒ Center will use anaphylactic and hypersensitivity protocol established by Cure Stat Infusion Services.

Special Instructions: _____

Quantity: _____ Refills: _____

Provider Signature: _____

Date: _____