



Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO9031



ADULT AMBULATORY INFUSION ORDER
methylPREDNISolone sodium succinate (SOLU-MEDROL)

Page 1 of 2

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE

Weight: _____ kg Height: _____ cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ Patient to follow up with provider on date: _____

****This plan will expire after 365 days at which time a new order will need to be placed****

LABS:

- Labs already drawn. Date: _____
- Basic Metabolic Set, Routine, ONCE, prior to therapy
- Basic Metabolic Set, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – *Circle One*

MEDICATIONS: (must check one)

methylPREDNISolone sodium succinate (SOLU-MEDROL)

- 500 mg in sodium chloride 0.9%, intravenous, ONCE, over 30 minutes
- 1000 mg in sodium chloride 0.9%, intravenous, ONCE, over 60 minutes
- _____ mg, intravenous, ONCE
 - Doses 125 mg and less will be IV push
 - Doses 126-499 mg will be in sodium chloride 0.9% over 15 minutes

Interval: (must check one)

- Once
- Once daily x _____ doses
- Every _____ days x _____ doses
- Every _____ weeks x _____ doses
- Every month x _____ doses

NURSING ORDERS:

1. TREATMENT PARAMETERS – If labs are ordered, hold methylPREDNISolone and notify MD for potassium less than 3.5 or greater than 5, or for glucose greater than 400
2. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.



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By signing below, I represent the following:

I am responsible for the care of the patient (*who is identified at the top of this form*);

I hold an active, unrestricted license to practice medicine in: Oregon _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____

Please check the appropriate box for the patient's preferred clinic location:

Hillsboro Medical Center

Infusion Services
364 SE 8th Ave, Medical Plaza Suite 108B
Hillsboro, OR 97123

Phone number: (503) 681-4124

Fax number: (503) 681-4120

Adventist Health Portland

Infusion Services
10123 SE Market St
Portland, OR 97216

Phone number: (503) 261-6631

Fax number: (503) 261-6756

Mid-Columbia Medical Center

Celilo Cancer Center
1800 E 19th St
The Dalles, OR 97058

Phone number: (541) 296-7585

Fax number: (541) 296-7610