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

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

MEDICATIONS: (must check one)

methylPREDNISolone sodium succinate (SOLU-MEDROL)
- 500 mg in NaCl 0.9% 250 mL, intravenous, ONCE, over 30 minutes
- 1000 mg in NaCl 0.9% 250 mL, intravenous, ONCE, over 60 minutes
- _________ mg, intravenous, ONCE
  - Doses 125 mg and less will be IV push
  - Doses 126-499 mg will be in NaCl 0.9% 50 mL 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 – Hold methylPREDNISolone and notify MD for potassium less than 3.5 or greater than 5. Hold methylPREDNISolone and notify MD for blood glucose greater than 250
2. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.
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: ________________

OLC Central Intake Nurse:
Phone: 971-262-9645 (providers only) Fax: 503-346-8058

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

☐ Beaverton
   OHSU Knight Cancer Institute
   15700 SW Greystone Court
   Beaverton, OR 97006
   Phone number: 971-262-9000
   Fax number: 503-346-8058

☐ NW Portland
   Legacy Good Samaritan campus
   Medical Office Building 3, Suite 150
   1130 NW 22nd Ave.
   Portland, OR 97210
   Phone number: 971-262-9600
   Fax number: 503-346-8058

☐ Gresham
   Legacy Mount Hood campus
   Medical Office Building 3, Suite 140
   24988 SE Stark
   Gresham, OR 97030
   Phone number: 971-262-9500
   Fax number: 503-346-8058

☐ Tualatin
   Legacy Meridian Park campus
   Medical Office Building 2, Suite 140
   19260 SW 65th Ave.
   Tualatin, OR 97062
   Phone number: 971-262-9700
   Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders