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:
- ☐ 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.
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:___________

Central Intake:
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

□ 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

□ 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

□ 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.ohsknight.com/infusionorders