



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

PO7071



ADULT AMBULATORY INFUSION ORDER
**methyIPREDNISolone 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*

NURSING ORDERS:

1. TREATMENT PARAMETERS – if labs are ordered:
Assess serum potassium. If potassium is 3.1-3.5 mmol/L order potassium chloride 40 mEq tablet by mouth, then proceed with treatment. HOLD treatment and notify provider if potassium < 3 mmol/L. Notify provider if glucose is greater than 400 mg/dL. Okay to proceed with treatment
2. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declothing (alteplase), and/or dressing changes.

MEDICATIONS: (must check one)

methyIPREDNISolone 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



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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:** _____

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|---|--|---|
| INFUSION REFERRAL TEAM Phone (providers only) (971) 262-9645 Fax completed orders to (503) 346-8058 Infusion orders located at: www.ohsuknight.com/infusionorders | <input checked="" type="checkbox"/> Please indicate the patient's preferred clinic location below | |
| | <input type="checkbox"/> BEAVERTON OHSU Knight Cancer Institute | 15700 SW Greystone Court Beaverton OR 97006 |
| | <input type="checkbox"/> NW PORTLAND Legacy Good Samaritan campus | Medical Office Building 3 – Suite 150 1130 NW 22nd Ave, Portland OR 97210 |
| | <input type="checkbox"/> GRESHAM Legacy Mount Hood campus | Medical Office Building 3 – Suite 140 24988 SE Stark, Gresham OR 97030 |
| | <input type="checkbox"/> TUALATIN Legacy Meridian Park campus | Medical Office Building 2 – Suite 140 19260 SW 65th Ave, Tualatin OR 97062 |