Ascend
INFUSION CENTERS

Please fax completed form, insurance card, and clinical documentation to:
**FAX: 843-793-6181**

## SOLUMEDROL ORDER

☐ **New Start** ☐ **Maintenance: Last Dose Given**_____

| Referring Office: | Contact Name: | Date: |
|---|---|---|
| Direct Phone for Contact: | Fax: | |
| Patient Name: | DOB: | |

Allergies ☐ NKDA ☐ Allergies: _____

Height: _____ Weight: _____

**Indication:**

☐ _____

☐ _____

**DOSAGE ORDERS:**

☐ Up to 55 kg 260 mg (2 vials)
☐ Greater than 55 kg to 85 kg 390 mg (3 vials)
☐ Greater than 85 kg 520 mg (4 vials)
☐ Other _____

**PREMEDICATION ORDERS:** *antihistamine and 100mg methylprednisolone are recommended in the PI*

☐ Acetaminophen po: ☐ 1000mg ☐500mg 30 min prior to infusion.
☐ Diphenhydramine: ☐ 25mg PO ☐ 50mg PO ☐ 25mg IVP 30 min prior to infusion.
☐ Other _____

| Prescriber Name: | Title: |
|---|---|
| NPI: | DEA: |
| Prescriber Signature: | Date of Order: |

**Referrals will not be processed until we receive <u>ALL</u> the following:**

☐ Face Sheet / Patient Demographics
☐ Insurance card(s) – copy of front & back
☐ Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes)
Most Recent Labs (within last 4-8 weeks) – Required:
☐ CBC ☐ CMP ☐ Lipids ☐ TB ☐ Hep B Other: _____