



St. Charles Health System

Adult Ambulatory Infusion Order
Methylprednisolone
(SOLUMEDROL)

Patient Name:
Date of Birth:

Patient Identification

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

Treatment Start Date: _____ Allergies: _____
Weight: _____ kg Height: _____ cm

REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety

- 1. FACE SHEET with complete INSURANCE information and patient CONTACT information**
- 2. Recent VISIT NOTE to support treatment (if not available in Epic)**
- 3. LAB RESULTS for any required prescreening (if not available in Epic)**
- 4. DIAGNOSIS CODE _____**
- 5. Patient NAME and DATE OF BIRTH on EVERY page faxed**

LABS:

- 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, hold methylPREDNISolone and notify MD for potassium less than 3.5 or greater than 5, or for glucose greater than 400.
2. VITAL SIGNS – Prior to infusion then PRN
3. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, dec clotting (alteplase), and/or dressing changes.

MEDICATIONS:

Select one of the following dosing schedules:

methylPREDNISolone sodium succinate (SOLU-MEDROL)

- 500 mg in sodium chloride 0.9%, intravenous 100 mL, ONCE, over 30 minutes
- 1000 mg in sodium chloride 0.9% 100 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 sodium chloride 0.9% 100 mL over 30 minutes

Interval: (must check one)

- Once
- Once daily x _____ doses
- Every _____ days x _____ doses
- Other _____



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INFUSION MONITORING/REACTION:

Infusion Reaction. Acute Infusion and Hypersensitivity Medication Protocol will be used unless the provider selects the option below. If opting out, alternative orders must be included.

1. diphenhydramine 25 mg IV, AS NEEDED x1 for hypersensitivity reaction
2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. methylprednisolone 125 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. sodium chloride 0.9% 1000 mL IV, 200 mL/hr, AS NEEDED x 1 dose for alteration in hemodynamic status
6. albuterol 2.5 mg/3 mL nebulizer, AS NEEDED x1 dose for hypersensitivity reaction

Opting out of standard protocol. Alternative orders are attached, or deviations are documented:

Patient will be treated at the following infusion location:

- St. Charles Outpatient Infusion Center
2500 NE Neff Road, Bend, OR 97701
Phone: (541) 706-5820 Fax: (541) 706-5825

By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION

Signature: _____ License #: _____ Date: _____

Print Name: _____ Phone: _____ Fax: _____

Plan will expire 1 year after signature date at which time a new order will need to be placed