Methylprednisolone Patient Referral and Prescription Sheet
Return Signed RX via Fax to 773-775-2732

To: Lynn Welch, Pharm.D	From:	Phone:
Intake phone: **800-831-7740**	Fax:	Number of Pages, Including Cover:
Date:	**DOB:**	**Allergies:**
Patient Name:	**Height:**	**Weight:**

Medication Order:

Methylprednisolone ______ gm in ______ mls in ______ L 0.9% Sodium Chloride infused once daily over 1 hour via homepump 100mL/hr.

Duration: x _________ days; last dose on __________________; **then discontinue above order and discharge patient.**

Has patient received above medication previously: Yes ☐ No ☐

Epi-Pen 0.3mg 2 PaK Auto Injector ☐

Intravenous Access: PERIPHERAL

Flush orders = protocol:

____________ 0.9% Sodium Chloride Flush: **3mL** before and after each infusion and PRN

____________ Heparin 100units/ml after last saline each infusion

Laboratory Orders:____

____

____

____

Diagnosis: ______________________________

Allergies: ______________________________

____

Chronic Conditions: __________________________

____

____

Date of Birth:	**Height:**	**Weight:**

Nursing Coverage: ________________________________ **Faxed** ☐ **Communicated** ☐

Please fax the following information:

- ☒ Methylprednisolone order – include dose, route of administration, frequency, duration, and any premedications **OR** use Rx order section above
- ☒ Patient demographics – include insurance information. **<u>We will obtain authorization</u>** unless the insurance dictates otherwise
- ☒ H & P **OR** progress note(s) describing diagnosis and clinical status
- ☒ Labs – BUN/Creatinine (preferred within last 90 days)

Orders Received via: : Faxed Prescription from MD ____

By: _____________________________________ MD Signature

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