# Solu-Medrol®

Provider Order Form Rev. 07/2023

Please fax completed referral form & all required documents to (833) 786-0025

HEALIX® INFUSION CARE

## PATIENT DEMOGRAPHICS

Patient Name: ______________________ DOB: ______________ Phone: ______________

Address: ______________________ City/ST/Zip: ______________________

Allergies: ______________________ ☐ NKDA Weight: ________ ☐ lbs ☐ kg Allergies: ______________

**Patient Status:** ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

**INSURANCE INFORMATION:** ***Please attach copy of insurance card (front and back).***

## DIAGNOSIS*

***ICD 10 Code Required***

☐ ______________________, ICD10 __________ ☐ ______________________, ICD10 __________

## INFUSION ORDERS

| MEDICATION | DOSE | DIRECTIONS/DURATION |
|---|---|---|
| Solu-Medrol® (methylprednisolone) | __________ mg | ☐ Infuse IV over ______ hours once daily x _______ days<br>☐ Infuse IV over ______ hours once monthly x _______ months<br>☐ Other: ______________________ |

**Is patient currently receiving therapy above from another facility?**

☐ Yes ☐ No

If yes, Facility Name: ______________________

Date of last treatment: ______________ Date of next treatment: ______________

### PRE-MEDICATION ORDERS

☐ No premeds ordered at this time

☐ Acetaminophen 650mg PO ☐ Diphenhydramine 25mg PO

☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IVP

☐ Other: ______________________

### LAB ORDERS

**Labs to be drawn by:** ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q _________ ☐ CMP q _________ ☐ CRP q _________

☐ ESR q _________ ☐ LFTs q _________ ☐ Other: ______________

## REFERRING PHYSICIAN INFORMATION

Physician Signature: ______________________ Date: ______________

Physician Name: ______________ Provider NPI: ______________ Specialty: ______________

Address: ______________________ City/ST/Zip: ______________

Contact Person: ______________ Phone #: ______________ Fax #: ______________

Email Where Follow Up Documentation Should Be Sent: ______________________

## REQUIRED CLINICAL DOCUMENTATION

**Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.**