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

PO7071

ADULT AMBULATORY INFUSION ORDER

methylPREDNISolone sodium succinate (SOLU-MEDROL)

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*

MEDICATIONS: ***(must check one)***

methylPREDNISolone 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

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. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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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**: _____

Central Intake:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient's preferred clinic location:

☐ **Beaverton**
OHSU Knight Cancer Institute
15700 SW Greystone Court
Beaverton, OR 97006
Phone number: 971-262-9000
Fax number: 503-346-8058

☐ **NW Portland**
Legacy Good Samaritan campus
Medical Office Building 3, Suite 150
1130 NW 22nd Ave
Portland, OR 97210
Phone number: 971-262-9600
Fax number: 503-346-8058

☐ **Gresham**
Legacy Mount Hood campus
Medical Office Building 3, Suite 140
24988 SE Stark
Gresham, OR 97030
Phone number: 971-262-9500
Fax number: 503-346-8058

☐ **Tualatin**
Legacy Meridian Park campus
Medical Office Building 2, Suite 140
19260 SW 65th Ave
Tualatin, OR 97062
Phone number: 971-262-9700
Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders