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

PO9031

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*

NURSING ORDERS:

1. TREATMENT PARAMETERS – if labs are ordered:
   Assess serum potassium. If potassium is 3.1-3.5 mmol/L order potassium chloride 40 mEq tablet by mouth, then proceed with treatment. HOLD treatment and notify provider if potassium < 3 mmol/L. Notify provider if glucose is greater than 400 mg/dL. Okay to proceed with treatmen
2. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

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

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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**: _____

☑ **Please indicate the patient's preferred clinic location below**

☐	**HILLSBORO MEDICAL CENTER** 364 SE 8th Ave, Medical Plaza Suite 108B, Hillsboro, OR 97123	Phone (503) 681-4124 Fax (503) 681-4120
☐	**ADVENTIST HEALTH – PORTLAND** Infusion Services, 10123 SE Market St, Portland, OR 97216	Phone (503) 261-6631 Fax (503) 261-6756
☐	**ADVENTIST HEALTH – COLUMBIA GORGE** **Celilo Cancer Center, 1800 E 19th St, The Dalles, OR 97058**	Phone **(541) 296-7585** Fax **(541) 296-7610**