INDY INFUSION

Fax Form to: 330-294-2082

Patient Name: _____

Date of Birth: _____ Weight: _____

IV Access: _____

Allergies: _____

Methylprednisolone (Solu-Medrol) Order Form

- **Orders are initiated unless crossed out by provider.**
- ❑ **Check box to initiate orders.**

Diagnoses:

❑ Multiple Sclerosis ICD-10: G 35

_____ ICD-10: _____

_____ ICD-10: _____

Medication Orders:

- Solu-Medrol 1 gram IV every 24 hours for 3 days
- Solu-Medrol _____ IV every _____ for _____
- Other: _____
- Alteplase 2mg IV to declot central IV access per Infusion Solutions protocol as needed for occlusion.
- Flush line with D5W, 0.9% NaCl and/or Heparin 10 units/ml or 100 units/ml per Infusion Solutions protocol.
- Lidocaine 1% - up to 0.2ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).
- Infusion Reaction Management per Infusion Solutions protocol as needed.

Nursing Orders:

❑ If no central IV access, RN to insert peripheral IV and rotate site every 72 to 120 hours or as needed.

❑ Other: _____

_____

_____

_____

Labs:

❑ _____ ❑ weekly ❑ every _____

❑ _____ ❑ weekly ❑ every _____

❑ _____ ❑ weekly ❑ every _____

_____ _____

Prescriber Signature *Date*

_____

Please Print Name