ALL ORDERS MUST BE SIGNED AND DATED BY THE REFERRING PROVIDER	
ALLERGIES/REACTIONS (REQUIRED):	Yakima Outpatient Infusion Care 808 N 39th Ave Yakima WA 98902 Phone: 509-575-1174 Fax: 509-577-5021
ORDERS WITH CHECK BOXES	When an order is optional (those with check boxes), providers are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.
CODE STATUS	Patients will be considered FULL CODE unless marked otherwise. If the patient has a POLST, advance directive, or living will, please include a copy with the orders.

METHYLPREDNISOLONE (SOLU-MEDROL)

Patient Name: _____ Date of Birth: _____

Patient Phone Number: _____ Patient Weight: _____ kg Patient Height: _____

DIAGNOSIS & ICD-10 CODE (REQUIRED):

- ❑ Multiple Sclerosis (ICD-10: _____)
- ❑ Other: _____ (ICD-10: _____)

REQUIRED: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs
If required documentation not received with this order, scheduling of treatment will be delayed until complete information is available

ROUTINE LABS (circle): CMP | CBC w/ diff | LFT | CRP | ESR | ❑ Other: _____

- ✓ **LAB FREQUENCY**: _____

IV ACCESS: *Access and/or maintain IV site or Port-A-Cath in accordance with the appropriate MYMH OIC P&Ps*

TREATMENT REGIMEN: *(another brand of drug, identical in form and content may be dispensed unless "DAW" or "BRAND ONLY" is written next to the drug name)*

METHYLPREDNISOLONE SODIUM SUCCINATE (Solu-Medrol) IV INFUSION

- ✓ 1000 mg IV in 100 mL 0.9% sodium chloride solution infused over 30 minutes daily

LENGTH OF THERAPY: ❑ 3 doses ❑ Other: _____ doses

ADDITIONAL INFORMATION/MONITORING: _____

SUPPORTIVE CARE: Administer hypersensitivity reaction/anaphylaxis management per MYMH OIC protocol as necessary.

DISCHARGE: 30 minutes after infusion when vital signs are stable, and no reaction is present. If no injection-related events with previous doses, may waive post-monitoring period and discharge home after completion.

Provider Signature: _____ Date: _____

Print name: _____ Phone # _____ Fax # _____

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Patient Identification - Attach Patient Label

Name:

MRN:

Age / Sex and Gender:

METHYLPREDNISOLONE (Solu-Medrol)

MultiCare

Yakima Memorial Hospital