SOLUMEDROL ORDERS

Please type or print. Complete ALL fields and fax to 817-553-1393. An incomplete form will delay the processing/scheduling of the patient. Thank you for your referral and allowing us to partner with you in the care of your patient. Call 817-553-1325 with any questions.

Patient Name: _____ **DOB:** _____

Phone: _____ **Allergies:** _____

Weight: _____ ❑ **lbs/**❑ **kg**

Primary Diagnosis _____ **ICD-10:** _____

(Please include supporting documentation with referral to avoid delay in treatment)

Please provide information along with order and fax to infusion department at 817-553-1393:

- ❑ Patient Demographics including copies of insurance cards
- ❑ Last office visit notes including supporting documentation for diagnosis to avoid delay in processing.

Prescription:

- ❑ IV Solumedrol (methylprednisolone) _____ MG x _____ day(s) for _____ week(s).
- ❑ Other orders:

_____

_____

Ordering Provider Information

Name _____

Address _____

_____

NPI # _____

Signed _____

Office Contact Information

Name _____

Phone ( ) _____-_____

Fax ( ) _____-_____

Email _____

Date _____ /_____ /_____