

SOLU-MEDROL Referral Form

PATIENT INFORMATION

Referral Status:

New Referral

Updated Order

Order Renewal

DOB:	Patient Name:	Patient Phone:	
Patient Address:		Patient Email:	
NKDA Allergies:	Weight (lbs/kg):		Height:
ICD-10 code (required):	ICD-10 description:	Last Treatment Date:	Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

NURSING

Infusion to be administered per BioHealth protocols.

SOLU-MEDROL THERAPY ADMINISTRATION

Please enter dose and frequency:

LABORATORY ORDERS

CBC At each dose Every _____
 CMP At each dose Every _____
 CRP At each dose Every _____
 OTHER _____

REQUIRED DOCUMENTATION

Patient Demographics

Insurance Card/Information

Progress Notes Supporting DX

Current Medication List and H&P

PREMEDICATIONS

acetaminophen (Tylenol) 500 mg 650 mg 10000 mg PO
 cetirizine (Zyrtec) 10mg PO
 loratadine (Claritin) 10mg PO
 diphenhydramine (Benadryl) 25 mg 50 mg PO IV
 methylprednisolone (Solu-Medrol) 40mg 125mg IV
 hydrocortisone (Solu-Cortef) 100mg IV
 Other: _____
 Dose: _____ Route: _____

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

Provider Name (Print)	Provider Signature	Date
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Have a Question? (786)460-6044
Fax Referral Form To: (786)219-3917
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