

IV Solu-Medrol Order

(Methyl-Prednisolone)



InfusionForHealth.com
Ph: 888-777-1945 | Fax: 805-852-2636

Date: _____ Treatment Location: _____

***Please fax a copy of the following patient information:**

☐ Demographics

☐ Insurance Information

☐ Current CBC & CMP

☐ H & P Relevant to the Diagnosis

☐ Current Medications

PATIENT INFORMATION

Patient Name: _____

DOB: _____

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

SOLU-MEDROL IV (METHYL-PREDNISOLONE)

Date of Last Treatment, If Continuation:

Dose: _____

Frequency: _____ Duration: _____

Start Date: _____