Infusion for Health
77 Rolling Oaks Drive, Suite 201
Thousand Oaks, CA 91361
Phone: 805-719-3700 Fax: 805-852-2636

IV SOLU-MEDROL ORDER
(Methyl-Prednisolone)

****Please fax a copy of patient's demographics, insurance information, current lab results, H&P relevant to diagnosis & current medications.***

Date: ____/____/____

Patient Name: ____ **DOB:**____/____/____

Allergies: ___________________________________ **Wt:** ______ **lbs / kg** **Ht:**__________

Diagnosis: ____

DX CODES: ICD-10: ____

Solu-medrol IV
(Methyl-Prednisolone)

Dose:____________________________

Frequency: _____________________________ **Duration:** ____________________

Start Date of Medication: _____/_____/_____

Printed Provider's Name: ____ **NPI:** ____________________

Provider's Signature: ____ **Date:**_____/_____/_____

Office phone number: _______________________________ **Office Fax:**______________________________

Office address: ____**Contact person:** __________________

Revised 10/19/17