aleracare
advanced infusion centers™

FAX 833.329.4738

Solumedrol (methylprednisolone)

Provider Order Form rev. 5/5/2023

Patient Information

Patient Name: DOB:

Patient Phone: Patient Email:

◯ NKDA ◯ Allergies: Weight lbs/kg: Height:

Patient Status: ◯ New to Therapy ◯ Continuing Therapy ◯ Therapy Change Next Due Date (if applicable):

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

Documentation Required (Note: Send all labs, must include specific labs listed here)

◯ Labs ◯ Insurance Card (front and back) ◯ Current Medications ◯ History/Progress Notes

ICD-10 CODE

◯ Other: _____

Medication Order

Solumedrol (methylprednisolone) **Dose:** ◯ _____ mg IV **Frequency:** ◯ _____

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

_____ _____ _____

Provider Name **Provider Signature** **Date**

Order Expiration Date (mm/dd/yy): _____ (If not indicated order will expire one year from date signature) Check here if this is a stat order ◯