

## Methylprednisolone IV (Solu-medrol)

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Patient Name	Middle	Last	DOB
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Diagnosis	Diagnosis Code
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Height (cm)	Actual Weight (kg)	Allergies
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Please list any premeds needed.

### METHYLPREDNISOLONE IV:

Drug Dose (mg): \_\_\_\_\_ Frequency: \_\_\_\_\_ Orders valid through: \_\_\_\_\_

\*\*Infusion rate will be over 30 min unless otherwise specified. \*\*

Other specified rate: \_\_\_\_\_

In the event of a hypersensitivity reaction, patients will be treated according to NECS protocols for the management of infusion-room drug reactions.

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Provider Name	Provider Signature		
Date	Phone	Fax	Pager