NEW ENGLAND
Cancer Specialists

**Infusion Center**

KENNEBUNK | ROCK ROW | TOPSHAM | PORTSMOUTH
PHONE: (207) 303-3225 | FAX: (207) 692-2473

# Methylprednisolone IV (Solu-Medrol)

Patient Name | Middle | Last | DOB

Diagnosis | Diagnosis Code

Height (cm) | Actual Weight (kg) | Allergies

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.

Provider Name | Provider Signature

Date | Phone | Fax | Pager