Northern Light Health

- ☐ NL Infusion Care, AR Gould, **Presque Isle**
  Phone: 207-768-4589; Fax: 207-768-4183
- ☐ NL Infusion Care, **Blue Hill**
  Phone: 207-374-3995; Fax: 207-374-3970
- ☐ NL Infusion Care, CA Dean, **Greenville**
  Phone: 207-695-5222; Fax: 207-695-4801
- ☐ NL Infusion Care, **Brewer**
  Phone: 207-973-9785; Fax: 207-973-9788
- ☐ NL Infusion Care, **Waterville**
  Phone: 207-861-3380; Fax: 207-861-3348
- ☐ NL Mary Dow Center, **Ellsworth**
  Phone: 207-664-5584; Fax: 207-664-5485
- ☐ NL Infusion Care, Mayo, **Dover-Foxcroft**
  Phone: 207-564-4254; Fax: 207-564-4418
- ☐ NL Mercy Cancer Care, **Portland**
  Phone: 207-553-6868; Fax: 207-904-0917
- ☐ NL Infusion Care, SVH, **Pittsfield**
  Phone: 207-487-4052; Fax: 207-487-3995

**PATIENT IDENTIFICATION**
**Known allergies / medication sensitivities:**

# OUTPATIENT METHYLPREDNISOLONE (SOLU-MEDROL) ORDERS



**Diagnosis:** _____ **ICD10:** _____

**IV Access:**

☐ Saline Lock:
- ☑ Insert peripheral Saline Lock; *may leave in for consecutive treatment days*
- ☑ Discontinue Saline Lock after therapy completed

☐ PICC Line:
- ☑ Routine PICC Line Care, labs and restoration
- ☐ Discontinue PICC Line (verify regimen is complete with provider prior to removing line)

☐ Porta cath / Central Access Device (Hickman, Triple lumen):
- ☑ Porta cath access, labs, restoration and de-access / Central Access Device use and care

**Height:** _____ cm **Weight:** _____ kg

**Medication:**

☐ SoluMedrol *1 gm, Soln, IVPB, Daily for _____ Doses/Times, SoluMedrol 1 gram/250 mL 0.9% Sodium Chloride IVPB, Infuse over 1 hour*

☐ SoluMedrol *1 gm, Soln, IVPB, Weekly for _____ Doses/Times, SoluMedrol 1 gram/250 mL 0.9% Sodium Chloride IVPB, Infuse over 1 hour*

☐ SoluMedrol *1 gm, Soln, IVPB, Monthly for _____ Doses/Times, SoluMedrol 1 gram/250mL 0.9% Sodium Chloride IVPB, Infuse over 1 hour*

☐ SoluMedrol _____, *Soln, IVPB, for _____ Doses/Times*

☑ Maalox *30 mL, Susp, PO, Every 4 hours, PRN, Heartburn and/or Indigestion*

**Other:** _____

Date: _____ Time: _____

Provider Signature: _____ Print Name: _____

Phone: _____ Fax: _____

Pharmacy Signature: _____

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**PROVIDERS MUST EXERCISE INDEPENDENT CLINICAL JUDGMENT WHEN USING ORDER SETS**