FirstHealth OF THE CAROLINAS

7096.08.16154.01 Sunset Date: 6/2024

OP Solumedrol Referral

1POREF001

Place Patient Label
Inside This Box

***** This section refers to the entire plan. If individual orders need a different interval, please indicate in each section below***** **Version 6/2021**

Date of Infusion: _____

Patient Name: _____

Patient SSN (if available): _____

Insurance Name: _____

Secondary Insurance: _____

Diagnosis Code: _____

Diagnosis Code Description: _____

Lead Physician _____

Date of Birth: _____

Contact Number: _____

Policy Number: _____

Policy Number: _____

Precertification: ☐ Initiated ☐ Complete

Location to be Performed:
☐ Moore Regional Hospital (MRH)
☐ Montgomery Memorial Hospital (MMH)

Interval _____ Day _____ of every _____ month

Minimum Separation _____ days / weeks (circle one)

Next Due Date _____

Duration: ☐ Until discontinued ☐ ____ Treatments
☐ Until _____

Nursing Orders	Interval	Duration
☐ **Insert peripheral IV** Once	_____	_____
PICC Access And Flush Orders		
☐ PICC Line Access Once	_____	_____
☐ heparin, porcine (PF) 10 unit/mL injection 50 Units 50 Units, intravenous, Once	_____	_____
Vascular Access Device (CVC) Access and Flush Orders		
☐ Central Venous Catheter (CVC) access Once	_____	_____
☐ heparin, porcine (PF) injection 500 Units 500 Units, intravenous, Once	_____	_____
Pre-Medications		
☐ sodium chloride 0.9 % infusion 500 mL 500 mL, intravenous, at 10 mL/hr, Once, For 1 Doses Carrier Fluid	_____	_____
Medications		
☐ methylPREDNISolone sodium succinate (Solu-MEDROL) 1 g in sodium chloride 0.9 % 250 mL IVPB 1 g, intravenous, for 60 Minutes	_____	_____

For Scheduling Fax Forms to: (910) 715-1177.

Provider Signature: _____ **Date:** _____ **Time:** _____

* May be used as EPIC Downtime Form