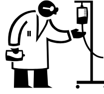

Infusion Associates
3230 Eagle Park NE, Suite 101
Grand Rapids, MI 49525
Phone: 616-954-0600 Fax: 616-954-1675

IV SOLU-MEDROL ORDERS

******Please fax a copy of patient's Demographics, Insurance information, Current Lab Results, H&P, and Current Medications*

Date: _____/_____/_____

Patient Name: ____ **DOB**: _____/_____/_____

Allergies: _______________________________ **Patient Weight:** _________lbs / kg **Height:**_________

Diagnosis:____

DX CODES: ***ICD-10*** **:** _______________________, _______________________, _____________________

Solu-medrol (Methyl-Prednisolone) IV

Dose:_____________________________

Frequency:___________________________________

Duration:____________________________________

Start Date of Medication: _____/_____/_____ **End Date of Medication**: _____/_____/_____

Printed Provider's Name: ____

Provider's Signature:____

Office phone number:______________________________ **Office Fax:**___________________________