

# SOLU-MEDROL Referral Form



**Patient Preferred Clinic** (select one):

## PATIENT INFORMATION

**Referral Status:**

New Referral

Updated Order

Order Renewal

DOB:	Patient Name:	Patient Phone:	
Patient Address:		Patient Email:	
NKDA Allergies:	Weight (lbs/kg):	Height:	
ICD-10 code (required):	ICD-10 description:	Last Treatment Date:	Last 4 SSN:

## PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

## NURSING

Infusion to be administered per VIVO protocols.

## SOLU-MEDROL THERAPY ADMINISTRATION

Please enter dose and frequency:

## LABORATORY ORDERS

CBC At each dose Every \_\_\_\_\_  
CMP At each dose Every \_\_\_\_\_  
CRP At each dose Every \_\_\_\_\_  
OTHER

## REQUIRED DOCUMENTATION

## PREMEDICATIONS

acetaminophen (Tylenol) 500 mg 650 mg 10000 mg PO  
cetirizine (Zyrtec) 10mg PO  
loratadine (Claritin) 10mg PO  
diphenhydramine (Benadryl) 25 mg 50 mg PO IV  
methylprednisolone (Solu-Medrol) 40mg 125mg IV  
hydrocortisone (Solu-Cortef) 100mg IV  
Other: \_\_\_\_\_  
Dose: \_\_\_\_\_ Route: \_\_\_\_\_

**Patient Demographics**

**Insurance Card/Information**

**Progress Notes Supporting DX**

**Current Medication List and H&P**

\*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. \*\*Order is valid for one year unless otherwise noted\*\*

**Provider Name (Print)** **Provider Signature** **Date**

<b>Fax Numbers</b>	Nevada: 702-489-5744	Massachusetts: 203-724-4838	<b>Have a Question? (720) 902-4111</b> <b>Email Referrals To: <a href="mailto:referrals@vivoinfusion.com">referrals@vivoinfusion.com</a></b>
Colorado: 303-418-4679	New Jersey: 609-955-3711	Pennsylvania: 215-399-9244	
Florida: 904-930-4211	Ohio: 216-400-0674	New York: 203-724-4838	
Texas: 469-340-0044	Oklahoma: 918-770-4421	Connecticut: 203-724-4838	