NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.℠

PATIENT IDENTIFICATION

MethylPREDNISolone REFERRAL FORM

NCH Homecare Infusion Pharmacy
Telephone: 614-355-1100 Fax: 614-355-1182

Section 1: Patient Information

Patient name (Last, First): _____ MRN_____Sex (circle one) ☐ M / ☐ F
DOB: _____Weight: _____ on (date) ___/___/_____ Allergies: _____
Diagnosis:_____ ICD10 Code _____
Initiate therapy in home between (dates): ___/___/_____ to ___/___/_____

Section 2: Ordering Information (must be signed by physician only)

Pre-Medications: (Oral medications to be supplied by family)
Administer 30 minutes prior to infusion, (if not given by family at home prior to visit)
☐ Acetaminophen PO x1: ☐325mg ☐500mg ☐650mg ☐10mg/kg (max 650 mg)
☐ Diphenhydramine PO x1: ☐12.5mg ☐25mg ☐ 50mg ☐ Other_____

Prn Medications: (Oral medications to be supplied by family)
☐ Ondansetron (Zofran) PO q8 hours prn nausea pre- and post- infusion ☐4mg ☐8mg
☐ Ibuprofen PO q6 hours prn pain/headache ☐400 mg ☐ 600mg ☐ Other_____

Infusion Medication:
☐ MethylPREDNISolone Sodium Succinate (may further dilute in NS prior to IV administration)

Dose: _____mg. Infuse IV every _____ weeks (over _____ minutes). Refills_____ doses or _____months.

☐ Other IV medications: _____

Catheter Care: Line type: ☐ Peripheral line ☐ Implanted port ☐ PICC ☐ Broviac ☐ Other: _____
☐ Lidocaine 4% Cream (L-M-X) 30 gm tube. Apply as directed and as needed prior to peripheral or implanted port access.
☐ 0.9% NaCl: Flush line with 10ml for implanted ports or 3-5 ml for other IV lines before and after MethyPREDNISolone and as needed.
☐ Heparin 100 units/ml: Flush line with 2ml after infusion for CVC and with 3ml after infusion for implanted ports.

Administration Orders:

1. Assess patient for any signs of acute illness (ie: fever (temp > 100.1), cough, flu-like symptoms…) if present, call the on-call Rheumatologist to determine if the infusion should be rescheduled.
2. Start peripheral IV or access central line prior to MethylPREDNISolone infusion.
3. Monitor vital signs (temperature, pulse, respirations, and blood pressure) prior to MethylPREDNISolone infusion.
4. Homecare to follow up with Rheumatology service via email (preferred) or fax at the completion of the infusion to confirm infusion given and tolerated **or** in the event that patient misses doses and/or scheduled visit.

Laboratory Orders:
Labs: ☐ CBC w/diff q___ weeks ☐ ESR/CRP q___ weeks ☐ Complete Metabolic panel q___ weeks
☐ Urinalysis q___ weeks ☐ Other _____

Ordering Physician (print): _____ (signature): _____

Date/Time: _____ Rheumatology Clinic Main Campus, 700 Children's Drive, Columbus, OH 43205 Phone: (614)722-5525