Solumedrol

Provider Order Form

rev. 12/01/2021

AleraCare
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PATIENT INFORMATION

Patient Name: DOB:

☐ NKDA Allergies: Weight lbs/kg:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

ICD-10 CODE

☐ ______________________________

MEDICATION ORDER

Solumedrol

________ mg IV q _______ weeks

Refills: ☐ Zero ☐ Other _________________

SPECIAL INSTRUCTIONS

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

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes)
☐ Lab Results
☐ Insurance Cards (front and back)
☐ Current Medication
☐ Demographic Sheet
☐ History and Physical Report

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months