

SOLU-MEDROL ORDER FORM

REFERRAL TYPE

New Referral
 Order Renewal
 Restart
 Frequency Change
 Dosage Change

PREFERRED LOCATION

<input type="checkbox"/> 2730 University Blvd. West Suite 714 Wheaton, MD 20902	<input type="checkbox"/> 14995 Shady Grove Road Suite 250 Rockville, MD 20850	<input type="checkbox"/> 5454 Wisconsin Avenue Suite 600 Chevy Chase, MD 20815
<input type="checkbox"/> 18111 Prince Philip Drive Suite 323 Olney, MD 20832	<input type="checkbox"/> 71 Thomas Johnson Drive Frederick, MD 21702	<input type="checkbox"/> 2021 K Street, NW Suite 300 Washington, DC 20006

PATIENT INFORMATION

Name:	DOB:	Email:
Address:	Weight: _____ KG _____ LBS	Phone:

REFERRING PHYSICIAN INFORMATION

Name:	NPI:	
Office Contact Name:	Phone:	Fax:
Address:		

SOLU-MEDROL ORDER

Dosing/Frequency:
 Dose: _____ Frequency: _____ Administration Time: _____

Diagnosis:

ICD-10 Code (Required):

Special Instructions:

Physicians Signature:	Date: _____ <i>(Order is Valid for One Year)</i>
-----------------------	--

REQUIRED DOCUMENTATION

- Please fax the following documents and records:**
- Patient Demographics
 - Two most recent office notes (Supporting the DX and treatment ordered)
 - Most recent labs that include values for:
 - CMP and CBC
 - Copy of the patient's insurance card(s) – front and back
 - Medication History
 - For continuation of treatment, include the last infusion note

We will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.