EAST TENNESSEE Children's Hospital

Print Patient Name (Required)

DOB

Height (cm): _____
Weight (kg): _____
BSA (m2): _____
Allergies: _____

Place Patient Barcode Here

Methylprednisolone (Solu-Medrol) Infusion

Admit to:	Diagnosis:	Infusion Date:

☐ Port ☐ Broviac ☐ PICC ☐ Place Peripheral IV ☑ Topical anesthetic per protocol
☑ Normal Saline/Heparin Flush per protocol

Premedications

☐ Acetaminophen = _____ mg PO (max dose 1000mg)
☐ Diphenhydramine = _____ mg IV or PO (max dose 50mg)
☐ Other: _____

Methylprednisolone _____ mg IV in NS over 1 hour

Nursing Orders

Weigh patient prior to infusion.
Monitor Vital Signs at the beginning and the end of the infusion.
Obtain the following labs with IV or central line access prior to the start of infusion: ☐ CBC ☐ CMP ☐ BMP ☐ ALT ☐ AST ☐ UA ☐ IGG ☐ IGG/IGA/IGM ☐ Other: _____ ***Fax all lab results to ordering provider***
☐ Discharge once infusion completed ☐ Discharge 30 minutes post infusion

PRN medications:

☐ Ibuprofen (10 mg/kg) = _____ mg (Max 800 mg) PO once prn mild pain/temp > 100.4 (call for fever prior to giving)

☐ Acetaminophen (15 mg/kg) = _____mg (max 650 mg) PO once prn mild pain/temp > 100.4 (call for fever prior to giving, must wait at least 4 hrs from any prior dose)

☐ Ondansetron (0.15 mg/kg) = _____ mg (max 8 mg) IV once prn nausea

Medications for allergic reaction (hives/itching/flushing, etc):

If allergic reaction occurs, call ordering provider immediately and give all medications ordered below. Do not delay administering medications on provider response. If ordering provider does not respond in 15 minutes call a Code Blue.

☐ Diphenhydramine (1mg/kg) = _____ mg (Max 50 mg) IV or PO once (must wait at least 4 hrs from any prior dose)

☐ Famotidine (0.5 mg/kg) = _____ mg (max 20 mg) IV once

For Anaphylaxis (Call a Code Blue):

☐ < 10 kg: Epinephrine 1 mg/mL (0.01 mg/kg) = _____ mg IM once

☐ 10 to < 25 kg: Epinephrine 0.15 mg auto-injector (EpiPen Jr.) IM once

☐ ≥ 25 kg: Epinephrine 0.3 mg auto-injector (EpiPen) IM once

Orders good until this date: _____ Subsequent Infusion Dates: _____

Provider's Signature: _____ Date: _____ Time: _____

Printed Name: _____