RADIOLOGY ASSOCIATES, P.A.

PREMEDICATION FOR PATIENTS WITH HISTORY OF CONTRAST ALLERGY

ROUTINE ORDERS

Patient Name ______________________________________

Height: __________________ Weight: ____________

Allergies: ____

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Exam ___________________________________ Date of Exam _______________________

Methyl Prednisolone:

32 mg PO at _____________ PM on _______________
(12 hours before exam) (Date)

AND

32 mg PO at _____________ AM on ______________
(At least 2 hours before exam) (Date)

Physician's Signature __________________________________ Date __________________

(Forms/PremedContrast)