

Date: _____

MIGRAINE infusion orders

Patient Name _____ DOB _____

Phone _____ ☐ Allergies M ☐ F ☐

NPI _____ Tax ID _____

Insurance Carrier (primary) _____

REFERRAL STATUS

Insurance Carrier (secondary) _____

New Prescription
Order Renewal
Does or Frequency Change
Discontinuation

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Migraine Headache

☐ _____ (other)

MIGRAINE ORDERS

ketoralac (Toradol)

☐ 30mg ☐ 60mg

magnesium sulfate

☐ 500mg ☐ 1000mg

valproate sodium (Depacon)

☐ 250mg ☐ 1000mg

dihydroergotamine mesylate (D.H.E 45)

☐ 0.25mg ☐ 0.50mg ☐ 1mg

ondansetron (Zofran)

☐ 4mg ☐ 8mg

dexamethasone (Decadron)

☐ 4mg ☐ 10mg ☐ 12mg

metoclopramide (Reglan)

☐ 5mg ☐ 10mg

Solu-Medrol (methylprednisolone)

☐ 125mg ☐ 500mg ☐ 1000mg

promethazine (Phenergan)

☐ 12.5mg ☐ 25mg

Other Medication: _____

Dosage: _____

IV FLUID ORDERS

0.9% Sodium Chloride

☐ 250ml ☐ 500ml ☐ 1000ml

☐ Give over _____ hours

☐ Give as bolus

5% Dextrose

☐ 250ml ☐ 500ml ☐ 1000ml

☐ Give over _____ hours

☐ Give as bolus

NOTES

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____