

Date: _____

MIGRAINE infusion orders

Patient Name _____ DOB _____

Phone _____ M F
 Allergies _____

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) <input type="radio"/> 30mg <input type="radio"/> 60mg	dexamethasone (Decadron) <input type="radio"/> 4mg <input type="radio"/> 10mg <input type="radio"/> 12mg
magnesium sulfate <input type="radio"/> 500mg <input type="radio"/> 1000mg	metoclopramide (Reglan) <input type="radio"/> 5mg <input type="radio"/> 10mg
valproate sodium (Depacon) <input type="radio"/> 250mg <input type="radio"/> 1000mg	Solu-Medrol (methylprednisolone) <input type="radio"/> 125mg <input type="radio"/> 500mg <input type="radio"/> 1000mg
dihydroergotamine mesylate (D.H.E 45) <input type="radio"/> 0.25mg <input type="radio"/> 0.50mg <input type="radio"/> 1mg	promethazine (Phenergan) <input type="radio"/> 12.5mg <input type="radio"/> 25mg
ondansetron (Zofran) <input type="radio"/> 4mg <input type="radio"/> 8mg	Other Medication: _____ Dosage: _____

IV FLUID ORDERS

0.9% Sodium Chloride <input type="radio"/> 250ml <input type="radio"/> 500ml <input type="radio"/> 1000ml <input type="radio"/> Give over _____ hours <input type="radio"/> Give as bolus	5% Dextrose <input type="radio"/> 250ml <input type="radio"/> 500ml <input type="radio"/> 1000ml <input type="radio"/> Give over _____ hours <input type="radio"/> Give as bolus
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NOTES

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____