Chicago Illinois
4711 Golf Road
Suite 900
Skokie, IL 60076

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

REJUVEINATE

Date: _____

MIGRAINE infusion orders

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐Discontinuation Order

PHYSICIAN INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Practice Address:	City: State: Zip Code:

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

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/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____