

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



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

Date: _____

MIGRAINE infusion orders

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS	
<input type="checkbox"/> New Referral	<input type="checkbox"/> Referral Renewal
<input type="checkbox"/> Medication/Order Change	<input type="checkbox"/> Benefits Verification Only
<input type="checkbox"/> 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:

<p>DIAGNOSIS <i>Please provide ICD-10 code</i></p> <p><input type="checkbox"/> _____ Migraine Headache</p> <p><input type="checkbox"/> _____ (other)</p> <p>MIGRAINE ORDERS</p> <p>ketoralac (Toradol) <input type="checkbox"/> 30mg <input type="checkbox"/> 60mg</p> <p>magnesium sulfate <input type="checkbox"/> 500mg <input type="checkbox"/> 1000mg</p> <p>valproate sodium (Depacon) <input type="checkbox"/> 250mg <input type="checkbox"/> 1000mg</p> <p>dihydroergotamine mesylate (D.H.E 45) <input type="checkbox"/> 0.25mg <input type="checkbox"/> 0.50mg <input type="checkbox"/> 1mg</p> <p>ondansetron (Zofran) <input type="checkbox"/> 4mg <input type="checkbox"/> 8mg</p>	<p>dexamethasone (Decadron) <input type="checkbox"/> 4mg <input type="checkbox"/> 10mg <input type="checkbox"/> 12mg</p> <p>metoclopramide (Reglan) <input type="checkbox"/> 5mg <input type="checkbox"/> 10mg</p> <p>Solu-Medrol (methylprednisolone) <input type="checkbox"/> 125mg <input type="checkbox"/> 500mg <input type="checkbox"/> 1000mg</p> <p>promethazine (Phenergan) <input type="checkbox"/> 12.5mg <input type="checkbox"/> 25mg</p> <p>IV FLUID ORDERS</p> <p>0.9% Sodium Chloride <input type="checkbox"/> 250ml <input type="checkbox"/> 500ml <input type="checkbox"/> 1000ml</p> <p><input type="checkbox"/> Give over _____ hours</p> <p><input type="checkbox"/> Give as bolus</p> <p>5% Dextrose <input type="checkbox"/> 250ml <input type="checkbox"/> 500ml <input type="checkbox"/> 1000ml</p> <p><input type="checkbox"/> Give over _____ hours</p> <p><input type="checkbox"/> Give as bolus</p>
--	---

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____