

Boca Raton
9980 Central Park Blvd
Suite 202, N
Boca Raton, FL 33428



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> <table><tbody><tr><td>0.9% Sodium Chloride</td><td>5% Dextrose</td></tr><tr><td><input type="checkbox"/> 250ml <input type="checkbox"/> 500ml <input type="checkbox"/> 1000ml</td><td><input type="checkbox"/> 250ml <input type="checkbox"/> 500ml <input type="checkbox"/> 1000ml</td></tr><tr><td><input type="checkbox"/> Give over _____ hours</td><td><input type="checkbox"/> Give over _____ hours</td></tr><tr><td><input type="checkbox"/> Give as bolus</td><td><input type="checkbox"/> Give as bolus</td></tr></tbody></table>	0.9% Sodium Chloride	5% Dextrose	<input type="checkbox"/> 250ml <input type="checkbox"/> 500ml <input type="checkbox"/> 1000ml	<input type="checkbox"/> 250ml <input type="checkbox"/> 500ml <input type="checkbox"/> 1000ml	<input type="checkbox"/> Give over _____ hours	<input type="checkbox"/> Give over _____ hours	<input type="checkbox"/> Give as bolus	<input type="checkbox"/> Give as bolus
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<input type="checkbox"/> Give as bolus	<input type="checkbox"/> Give as bolus								

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____