☐ *Borough Park*
1428 36th Street
Suite 107
Brooklyn, NY 11218

☐ *Crown Heights*
555 Lefferts Avenue
Brooklyn, NY 11225

☐ *Manhattan*
57W 57Street
Suite 601
New York, NY 10019

☐ *Manhasset*
333 East Shore Road
Suite 201
Manhasset, NY 11030

☐ *Rockville Centre*
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

☐ *Elmsford/ Terrytown*
555 Taxter Road
3rd Floor
Elmsford, NY 10523

☐ *NYC Central Park West*
115 Central Park West
Suite 15
New York, NY 10023

☐ *Woodbury*
75 Froehlich Farm
Woodbury, NY 11797

☐ *Staten Island*
27 New Dorp Lane
Staten Island, NY 10306

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

Mission Medical

☐ *Manhattan*
225 E 70th Street
Suite 1E
New York, NY 10021

☐ *Holbrook/ Ronkonkoma*
233 Union Ave
Suite 207
Holbrook, NY 11741

☐ *Long Beach*
917 Beech Street
Long Beach, NY 11561

☐ *Queens*
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

☐ *Scarsdale*
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

☐ *Riverhead*
1228 E Main Street
Suite A
Riverhead, NY 11901

☐ *Manhattan*
225 East 70th Street
New York, NY 10021

☐ *5 Towns*
141 Washington Avenue
Cedarhurst, NY 11559

☐ *Bronx*
226 West 238th Street
Bronx, NY 10463

MIGRAINE infusion orders

Date: _____

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 _____