

# Migraine Infusion Order

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  Male  Female

Diagnosis (please provide ICD10 code): \_\_\_\_\_

Other: \_\_\_\_\_

NKDA  Allergies: \_\_\_\_\_

New Therapy Order  Continuation of Therapy Date of last dose: \_\_\_\_\_

Ordering Provider Name: \_\_\_\_\_

Provider NPI: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Required Documentation:**

- Patient Demographics
- Patient Insurance (med and pharm card copies, front and back)
- Progress Notes/Labs supporting diagnosis
- Other: \_\_\_\_\_

**Patient height and weight:**

Patient Height(cm): \_\_\_\_\_

Patient Weight (kg): \_\_\_\_\_

**Migraine Medication Order:**

▪ **Dosing (Please choose applicable)**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Methylpredisolone (Solu-Medrol) | <input type="checkbox"/> Dihydroergotamine mesylate (D.H.E. 45) | <input type="checkbox"/> Dexamethasone (Decadron) |
| <input type="checkbox"/> 125mg                           | <input type="checkbox"/> 0.25mg                                 | <input type="checkbox"/> 4mg                      |
| <input type="checkbox"/> 500mg                           | <input type="checkbox"/> 0.50mg                                 | <input type="checkbox"/> 10mg                     |
| <input type="checkbox"/> 1000mg                          | <input type="checkbox"/> 1mg                                    | <input type="checkbox"/> 12mg                     |
| <input type="checkbox"/> Ondansetron (Zofran)            | <input type="checkbox"/> Magnesium Sulfate                      | <input type="checkbox"/> Metoclopramide (Reglan)  |
| <input type="checkbox"/> 4mg                             | <input type="checkbox"/> 500mg                                  | <input type="checkbox"/> 5mg                      |
| <input type="checkbox"/> 8mg                             | <input type="checkbox"/> 1000mg                                 | <input type="checkbox"/> 10mg                     |
| <input type="checkbox"/> Ketoralac (Toradol)             | <input type="checkbox"/> Valproate Sodium (Depacon)             | <input type="checkbox"/> Promethazine (Phenergan) |
| <input type="checkbox"/> 30mg                            | <input type="checkbox"/> 250mg                                  | <input type="checkbox"/> 12.5mg                   |
| <input type="checkbox"/> 60mg                            | <input type="checkbox"/> 1000mg                                 | <input type="checkbox"/> 25mg                     |

▪ **IV Fluid Orders (Please choose applicable)**

- |   |                                      |  |
|---|--------------------------------------|--|
| <input type="checkbox"/> 0.9% Sodium Chloride | <input type="checkbox"/> 5% Dextrose | ▪ Administration                             |
| ▪ Volume                                      | ▪ Volume                             | <input type="checkbox"/> Give over ___ hours |
| <input type="checkbox"/> 250mL                | <input type="checkbox"/> 250mL       | <input type="checkbox"/> Give as bolus       |
| <input type="checkbox"/> 500mL                | <input type="checkbox"/> 500mL       |  |
| <input type="checkbox"/> 1000mL               | <input type="checkbox"/> 1000mL      |  |

▪ **Frequency (Please choose one)**

- Daily for \_\_\_\_\_ doses
- Weekly for \_\_\_\_\_ doses
- Bi-weekly for \_\_\_\_\_ doses
- Monthly for \_\_\_\_\_ doses
- Other: \_\_\_\_\_

<p><b>Additional Instructions/Notes:</b></p>  	<p><b>Patient IV Access</b></p> <input type="checkbox"/> PIV <input type="checkbox"/> Use patient's SL/DL PICC, flush per protocol <input type="checkbox"/> Access/deaccess patient's Port, flush per protocol <small>*Imaging results of proper placement required for PICC/Port</small>
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**Ordering Provider:**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Provider: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Best Contact Person in Office: \_\_\_\_\_

Phone: \_\_\_\_\_

**Locations:**

- Skokie, IL: 4711 Golf Rd, Ste 900. P: 847-324-6800. F: 224-251-7141
- Libertyville, IL: 1900 Hollister Dr, Ste 210. P: 847-324-6800. F: 224-251-7141
- Houston, TX: 8303 SW Freeway, Ste 111. P: 346-738-9600. F: 346-613-8400