Migraine orders

Please type or print. Complete ALL fields and fax to 817-553-1393. An incomplete form will delay the processing/scheduling of the patient. Thank you for your referral and allowing us to partner with you in the care of your patient. Call 817-553-1325 with any questions.

Patient Name: _____DOB: _____

Phone: _____Allergies: _____

Weight: _____ ❑ lbs/❑ Kg Primary Diagnosis _____ICD-10: _____

Prior to the infusion, please obtain and send results with your order:

- ❑ Patient Demographics including copies of insurance cards
- ❑ Last office visit notes including supporting documentation for ICD-10 codes to avoid delay in processing.

PRESCRIPTION: check all that apply (Order expires in 1 year)

- ❑ 1 Liter of Normal Saline 0.9% IV over at least 1 hour.
- ❑ 500 ml Normal Saline 0.9% IV over at least 30 minutes.
- ❑ Ketorolac 30 mg IVP x1
- ❑ Ondansetron 4 mg IVP, may repeat x1 for c/o nausea.
- ❑ Promethazine 12.5mg IV over at least 15 minutes.
- ❑ Promethazine 25mg IV over at least 30 minutes.
- ❑ Metoclopramide 5 mg IVP, May repeat x1 for c/o nausea.
- ❑ Magnesium Sulfate 1 gram IV over at least 30 minutes.
- ❑ Magnesium Sulfate 500 mg IV over at least 20 minutes.
- ❑ Valproate Sodium 500 mg IV over at least 30 minutes.
- ❑ Valproate Sodium 1 gram IV over at least 1 hour.
- ❑ Methylprednisolone 1 gram IV over at least 30 minutes
- ❑ Methylprednisolone 500 mg IV over at least 15 minutes.
- ❑ Decadron 10 mg IV over at least 10 minutes.
- ❑ DHE 1 mg IV over at least 30 minutes.
- ❑ Robaxin 1,000 mg IV over at least 20 minutes.

❑ Other orders: _____

Ordering Provider Information

Name _____

Address _____

_____

NPI # _____

Signed _____

Office Contact Information

Name _____

Phone ( ) _____-_____

Fax ( ) _____-_____

Email _____

Date _____ /_____ /_____