

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____
 ADDRESS: _____ CITY, STATE, ZIP: _____
 DATE OF BIRTH: _____ EMAIL: _____
 ALLERGIES: SEE LIST NKDA WEIGHT: LB OR KG

REQUIRED DOCUMENTATION

1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Medication List 5. Most Recent Labs

PRIMARY DIAGNOSIS

G43.009 Migraine w/o aura, not intractable, w/o status migrainosus G43.709 Chronic migraine w/o aura, not intractable, w/o status migrainosus
 G43.711 Chronic migraine w/o aura, intractable, with status migrainosus G43.719 Chronic migraine w/o aura, intractable, w/o status migrainosus
 Other _____

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRIMARY MEDICATION ORDER

Anti-convulsant <input type="checkbox"/> Keppra 500mg in 100ml IVPB over 20 minutes <input type="checkbox"/> Valproic acid 500mg in 100ml IVPB over 1 hour <input type="checkbox"/> Other: _____	Analgesic <input type="checkbox"/> Ketorolac 30mg IVP over 15 seconds <input type="checkbox"/> DHE 45 1mg in 100ml IVPB over 30 minutes <input type="checkbox"/> Other: _____
Antihistamine <input type="checkbox"/> Benadryl 25mg IVP over 1 min <input type="checkbox"/> Other: _____	IV Fluids <input type="checkbox"/> NS 1000ml IV over 1 hour <input type="checkbox"/> Other: _____
Magnesium <input type="checkbox"/> Magnesium sulfate 1g in 50ml NS IVPB over 30 minutes or in 1L NS main line over 1 hour <input type="checkbox"/> Other: _____	Steroid <input type="checkbox"/> Dexamethasone 10mg in 50ml IVPB or IVP undiluted over 1 min <input type="checkbox"/> Methylprednisolone 125mg in 50ml IVPB or IVP undiluted over 3-5 min <input type="checkbox"/> Other: _____
Anti-emetic <input type="checkbox"/> Ondansetron 4mg IVP over 30 seconds <input type="checkbox"/> Promethazine 25mg IVP in 10ml NS over 1 min <input type="checkbox"/> Prochlorperazine 10mg IVP over 2 min <input type="checkbox"/> Metoclopramide 10mg IVPB in 50ml NS over 20 minutes or IVP undiluted over 1 min <input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____ Frequency: <input type="checkbox"/> Administer every: _____ weeks for _____ months -or- <input type="checkbox"/> One time only

LINE USE/CARE ORDERS

Start PIV/ACCESS CVC Flush device per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)
 Other Flush Orders: Please send other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

Administer acute infusion and anaphylaxis medications per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)
 Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____
 OFFICE CONTACT: _____ FAX: _____
 ADDRESS: _____ EMAIL: _____
 CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

X

PROVIDER SIGNATURE _____ DATE _____