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adaptIV infusion

# Migraine

*Provider Order Form rev. 4/10/2022*

## PATIENT INFORMATION

Referral Status *(check one)*: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: ____________________ DOB: __________

NKDA ☐ Allergies: ____________________ Weight ______ *Please specify:* ☐ lbs ☐ kg Height: ______

Patient Status *(check one)*: ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: __________ Next Due Date: __________

ICD-10 code (required): __________ ICD-10 description: ____________________

**REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

## PRESCRIPTION

### NURSING

☐ Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation

### MIGRAINE ORDERS

ketorolac (Toradol) ☐ 30mg | ☐ 60mg
magnesium sulfate ☐ 500mg | ☐ 1000mg
valproate sodium (Depacon) ☐ 250mg | ☐ 1000mg
dihydroergotamine mesylate (D.H.E 45) ☐ 0.25mg | ☐ 0.5mg | ☐ 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
Other Medication: ____________________
Dosage: ____________________

### IV FLUID ORDERS

0.9% Sodium Chloride
☐ 250ml | ☐ 500mll | ☐ 1000ml
☐ Give over __________ hours
☐ Give as bolus

5% Dextrose
☐ 250ml | ☐ 500mll | ☐ 1000ml
☐ Give over __________ hours
☐ Give as bolus

## SPECIAL INSTRUCTIONS

## PROVIDER INFORMATION

Referral Coordinator Name: ____________________ Referral Coordinator Email: ____________________

Ordering Provider: ____________________ Provider NPI: ____________________

Referring Practice Name: ____________________ Phone: __________ Fax: __________

Practice Address: ____________________ City: __________ State: ______ Zip Code: ______

*Provider Name (Print)* ____________________ *Provider Signature* ____________________ *Date* __________

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK