MIGRAINE COCKTAIL

FLEXCARE INFUSION CENTERS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • History & Physical • Patient Demographics • Most Recent Labs • Medication List

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 migrainosos
☐ Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

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

PRIMARY MEDICATION ORDER

Anti-convulsant
☐ Keppra 500mg in 100ml IVPB over 20 minutes
☐ Valproic acid 500mg in 100ml IVPB over 1 hour
☐ Other:_____

Antihistamine
☐ Benadryl 25mg IVP over 1 min
☐ Other:_____

IV Fluids
☐ NS 1000ml IV over 1 hour
☐ Other:_____

Magnesium
☐ Magnesium sulfate 1g in 50ml NS IVPB over 30 minutes or in 1L NS main line over 1 hour
☐ Other:_____

Analgesic
☐ Ketorolac 30mg IVP over 15 seconds
☐ Other:_____

Steroid
☐ Dexamethasone 10mg in 50ml IVPB or IVP undiluted over 1 min
☐ Methylprednisolone 125mg in 50ml IVPB or IVP undiluted over 3-5 min
☐ Other:_____

Anti-emetic
☐ Ondansetron 4mg IVP over 30 seconds
☐ Promethazine 25mg IVP in 10ml NS over 1 min
☐ Prochlorperazine 10mg IVP over 2 min
☐ Metoclopramide 10mg IVPB in 50ml NS over 20 minutes or IVP undiluted over 1 min
☐ Other:_____

☐ Other:_____

_____

Frequency: ☐ Administer every _____ weeks for _____ months -or- ☐ One time only.

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____
Provider Signature Date

FAX: (888) 219-8102 | EMAIL: orders@flexcareinfusion.com | VISIT: flexcareinfusion.com/referrals