Fax: 561-516-6626 | Email: Info@infuseone.com | Phone: 561-337-4055

INFUSE ONE

MIGRAINE infusion orders

Patient Name _____ DOB _____

Phone _____ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Migraine Headache ☐ _____ _____ *(other)*

MIGRAINE ORDERS

ketorolac (Toradol)
○ 30mg ○ 60mg

magnesium sulfate
○ 500mg ○ 1000mg

valproate sodium (Depacon)
○ 250mg ○ 1000mg

dihydroergotamine mesylate (D.H.E 45)
○ 0.25mg ○ 0.50mg ○ 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 ○ 500ml ○ 1000ml
○ Give over _____ hours
○ Give as bolus

5% Dextrose
○ 250ml ○ 500ml ○ 1000ml
○ Give over _____ hours
○ Give as bolus

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

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