Migraine Cocktail

Provider Order Form Rev. 07/2023

Please fax completed referral form & all required documents to (833) 786-0025

HEALIX INFUSION CARE

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Migraine without aura (G43.001-G43.019), ICD10 _____

☐ Migraine with aura (G43.101-G43.119), ICD10 _____

☐ Chronic migraine without aura (G43.701-G43.719), ICD10 _____

☐ Other migraine (G43.801-G43.839), ICD10 _____

☐ Migraine, unspecified (G43.901-G43.919), ICD10 _____

☐ Other: _____, ICD10 _____

INFUSION ORDERS

Select drug(s) for administration:

☐ 0.9% Sodium Chloride 1 L IV over 31-60 minutes

☐ Diphenhydramine 12.5 mg - 50 mg IVP

☐ Ketorolac 15 mg - 30 mg IVP or IM -OR- ☐ Ketorolac 30 mg – 60 mg IVP or IM (if no history of kidney disease)

☐ Ondansetron 4 mg – 8 mg IVP

☐ Metoclopramide 10 mg SIVP or IM

☐ Dexamethasone 4 mg – 8 mg IVP or IM

☐ Methylprednisolone 125 mg IVP or IM

☐ Magnesium sulfate 1000 mg in 100 mL 0.9% Sodium Chloride IV over 15 minutes.

☐ May add to 0.9% Sodium Chloride 1 L bag (if selected above) and infuse IV over 31-60 minutes

☐ Valproate sodium 500 mg in 100 mL 0.9% Sodium Chloride IV over 15 minutes; may repeat in 30 minutes if no resolution of headache.

- Maximum daily dose up to 2 grams of valproate sodium)

☐ Other (no controlled substances): _____

Is patient currently receiving therapy above from another facility? ☐ **NO** ☐ **YES**

If yes, Facility Name: _____ Date of last treatment: _____ Date of next treatment: _____

OTHER ORDERS

LAB ORDERS: Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____ ☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

ADDITIONAL ORDERS: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.