MIGRAINE
INFUSION ORDERS

****REQUIRED INFORMATION****

- ☐ This order signed by provider
- ☐ Patient demographics & insurance information
- ☐ Clinical/progress notes to support primary diagnosis

Patient name:	DOB:
Allergies:	Patient Phone:

Diagnosis:

- ☐ Migraine (ICD-10_____)
- ☐ Other:_____ (ICD-10_____)

Patient weight: _____ kg

Migraine Orders

- ☐ Reglan 10mg IV
- ☐ Pepcid 20mg IV
- ☐ Zofran 4mg IV - may repeat x 1
- ☐ Zofran 8mg IV
- ☐ Solu-Medrol 125 IV
- ☐ Toradol 30mg IV - may dose mg BID, at least 6 hours apart -may recieve up to 3 days max

- ☐ Other:_____

- ☐ Magnesium Sulfate 1gm IV in 250mL NS over 1hr (1 gram max dose)
- ☐ DHE 45 0.5mg 1mg IV in 100mL NS (max 2mg in 24° and/ or 6mg/ week) (must be pre-medicated for nausea)
- ☐ Depacon 500mg 750mg IV in 250mL NS over 1 hr

Standing Order:

☐ 1 month ☐ 2 months ☐ 3 months

Max treatment in 7 day period: _____

Additional instructions:

Physician Name:	Phone:	Fax:

Physician Signature:	Date: