CURBSIDE INFUSION SERVICES

Fax To: 281-406-1047
Email To: referrals@curbsideinfusion.com
Office: 281-406-1046

MIGRAINE infusion orders

Patient Name _____ DOB _____

Phone _____ M ◯ F ◯

DIAGNOSIS *Please provide ICD-10 code*

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

MIGRAINE ORDERS

ketorolac (Toradol)
◯ 30mg ◯ 60mg

dexamethasone (Decadron)
◯ 4mg ◯ 10mg ◯ 12mg

magnesium sulfate
◯ 500mg ◯ 1000mg

metoclopramide (Reglan)
◯ 5mg ◯ 10mg

valproate sodium (Depacon)
◯ 250mg ◯ 1000mg

Solu-Medrol (methylprednisolone)
◯ 125mg ◯ 500mg ◯ 1000mg

dihydroergotamine mesylate (D.H.E 45)
◯ 0.25mg ◯ 0.50mg ◯ 1mg

promethazine (Phenergan)
◯ 12.5mg ◯ 25mg

ondansetron (Zofran)
◯ 4mg ◯ 8mg

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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