Site of Care
Infusion Center Only

Fax Referral to (855) 644-3687 or Email: Referrals@sandshealth.com

DIHYDROERGOTAMINE (DHE) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Mobile Number: _____

Patient Weight: _____ Patient Height: _____ Allergies: _____

Other Medications: _____

DIAGNOSIS (Provider must specify)

☐ Migraine, ICD10: _____

☐ Other: _____

Prior to treatment – ensure the following information is complete and attached with referral:

☐ Demographic ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

☐ Acetaminophen (Tylenol) 500 MG PO ☐ Benadryl 25mg PO ☐ Methylprednisolone (Solu-Medrol) _____ mg IVP

☐ Other: _____ Dose: _____ Route: _____

☐ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE
Dihydroergotamine	☐ **Initial dose**: dihydroergotamine (DHE) 0.5 mg in 100 mL of NaCl 0.9%, intravenous, over 1 hour. **If well tolerated, escalate dosing as follows**: ☐ **Day 2**: 8 hours later: dihydroergotamine (DHE) 0.75 mg in 250 mL of NaCl 0.9%, intravenous, over 1 hour ☐ **Day 3 and subsequent doses**: dihydroergotamine (DHE) 1 mg in 250 mLs of NaCl 0.9%, intravenous, over 1 hour every 8 hours for 10 doses. Other: _____

☐ New Start ☐ Continuation of Therapy Date of last dose (if applicable): _____

LABS/SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified: _____

PROVIDER INFORMATION

Provider Name: _____ Provider NPI: _____ Contact: _____

Phone: _____ Fax: _____ Email Address: _____

Signature: _____ Date: _____