Site of Care
Infusion Center Only

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

MIGRAINE COCKTAIL ORDER FORM

PATIENT INFORMATION

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

Prior to treatment – ensure the following information is complete and attached with referral:
☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

DIAGNOSIS

☐ G43.009 Migraine w/o aura, not intractable, w/o status migrainosus
☐ G43.709 Chronic migraine w/o aura, not intractable, w/o status migrainosus
☐ G43.711 Chronic migraine w/o aura, intractable, with status migrainosus
☐ G43.719 Chronic migraine w/o aura, intractable, w/o status migrainosos
☐ Other: _____

LAB ORDERS

_____
_____
_____
_____

MEDICATION/S

Anti-convulsant
☐ Keppra 500mg in 100ml IVPB over 20 minutes
☐ Valproic acid 500mg in 100ml IVPB over 1 hour
☐ Other:_____

Antihistamine
☐ Benadryl 25mg IVP over 1 min
☐ Other:_____

IV Fluids
☐ NS 1000ml IV over 1 hour
☐ Other:_____

Magnesium
☐ Magnesium sulfate 1g in 50ml NS IVPB over 30 minutes or in 1L NS main line over 1 hour
☐ Other:_____

Analgesic
☐ Ketorolac 30mg IVP over 15 seconds
☐ DHE 45 1mg in 100ml IVPB over 30 minutes
☐ Other:_____

Steroid
☐ Dexamethasone 10mg in 50ml IVPB or IVP undiluted over 1 min
☐ Methylprednisolone 125mg in 50ml IVPB or IVP undiluted over 3-5 min
☐ Other:_____

Anti-emetic
☐ Ondansetron 4mg IVP over 30 seconds
☐ Promethazine 25mg IVP in 10ml NS over 1 min
☐ Prochlorperazine 10mg IVP over 2 min
☐ Metoclopramide 10mg IVPB in 50ml NS over 20 minutes or IVP undiluted over 1 min
☐ Other:_____

☐ Other:_____

_____

Frequency: ☐ Administer every _____ weeks for _____ months -or- One time only.

PROVIDER INFORMATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	Fax:
NPI AND License:	Email:

_____ _____
Provider Signature Date