

HEADACHE ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI _____ DOB: _____

HT: _____ in WT: _____ lbs kg Sex: Male Female Allergies: NKDA, _____

Physician Name _____ Contact Name _____ Contact Phone # _____

NPI #: _____ Tax ID#: _____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 Code plus Description)

_____ Date of Diagnosis: _____

PERTINENT MEDICAL HISTORY

Does patient have venous access? YES NO If yes, what type MEDIPOINT PIV PICC LINE OTHER: _____

a) 500 mL BAG OF 0.9% NS MAY BE HUNG AT KVO RATE

PRESCRIPTION ORDERS

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
<input type="checkbox"/>	BENADRYL				
<input type="checkbox"/>	COMPAZINE				
<input type="checkbox"/>	DEPACON				
<input type="checkbox"/>	DHE 45				
<input type="checkbox"/>	DILANTIN				
<input type="checkbox"/>	KEPPRA				
<input type="checkbox"/>	KETOROLAC				
<input type="checkbox"/>	METHYLPREDNISOLONE				
<input type="checkbox"/>	METOCLOPRAMIDE				
<input type="checkbox"/>	ORPHENADRINE				
<input type="checkbox"/>	PROMETHAZINE				
<input type="checkbox"/>	VYEPTI	100 mg	IV	Once Every 3 Months	
<input type="checkbox"/>	0.9% NS				

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE
<input type="checkbox"/>	NONE	NA	NA
<input type="checkbox"/>	BENADRYL		IV
<input type="checkbox"/>	ACETAMINOPHEN		
<input type="checkbox"/>	OXYGEN		
<input type="checkbox"/>	ZOFRAN		IV
<input type="checkbox"/>	Other:		
<input type="checkbox"/>	Other:		

LABS

SELECT	LAB REQUESTED	WHEN	FREQUENCY
<input type="checkbox"/>	NONE	NA	NA
<input type="checkbox"/>	BMP	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	CMP	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	BUN/CREATININE	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	CRP:	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	ESR:	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	Other:	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	

Physician's Signature _____ Time _____ Date _____
 *Signature Must Be Clear and Legible

Cosignature (If Required) _____ Time _____ Date _____
 *Signature Must Be Clear and Legible

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.