SEMINOLE HOSPITAL DISTRICT
INFUSION CENTER
Phone: 432-758-4716 Fax: 877-249-1191

☐ **STAT REFERRAL**

HEADACHE ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ in WT: _____ kg Birth Sex :( ) Male ( ) Female Allergies: ( ) NKDA, (Or):_____

_____

Provider 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** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

PRESCRIPTION ORDERS

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
	BENADRYL (diphenhydramine)				
	COMPAZINE (prochlorperazine)				
	DEPACON (valproate)				
	DHE 45 (dihydroergotamine)				
	DILANTIN (phenytoin)				
	KEPPRA (levetiracetam)				
	KETOROLAC (Toradol)				
	SOLU-MEDROL (methylprednisolone)				
	REGLAN (metoclopramide)				
	NORFLEX (orphenadrine)				
	PHENERGAN (promethazine)				
	VYEPTI	**100 mg**	**IV**	**Once Every 3 Months**	
	0.9% SODIUM CHLORIDE				

PREMEDS

SELECT BELOW	MEDICATION	DOSE	ROUTE
	NONE	**NA**	**NA**
	BENADRYL (diphenhydramine)		
	TYLENOL (acetaminophen)		
	ZOFRAN (ondansetron)		
	Other:		
	Other:		
	OXYGEN		

LABS

SELECT BELOW	LAB REQUESTED	WHEN	FREQUENCY
	NONE	**NA**	**NA**
	BMP	**( ) PRIOR ( ) POST**	
	CMP	**( ) PRIOR ( ) POST**	
	BUN/CREATININE	**( ) PRIOR ( ) POST**	
	CRP:	**( ) PRIOR ( ) POST**	
	ESR:	**( ) PRIOR ( ) POST**	
	Other:	**( ) PRIOR ( ) 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.