Center for Infusion Care

Phone: (517) 212-4336 | **Fax:** (877) 249-1191
hillsdalehospital.com/infusion

STAT REFERRAL

HEADACHE ORDER FORM

PATIENT INFORMATION

Last Name: ______________ First Name: ______________ MI____ DOB:____________

HT: _________ in WT: ________ 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** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**________________________

PRESCRIPTION ORDERS

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
☐	BENADRYL				
☐	COMPAZINE				
☐	DEPACON				
☐	DHE 45				
☐	DILANTIN				
☐	KEPPRA				
☐	KETOROLAC				
☐	METHYLPREDNISOLONE				
☐	METOCLOPRAMIDE				
☐	ORPHENADRINE				
☐	PROMETHAZINE				
☐	VYEPTI	100 mg	IV	Once Every 3 Months	
☐	0.9% NS				

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE
☐	NONE	NA	NA
☐	BENADRYL		IV
☐	ACETAMINOPHEN		
☐	OXYGEN		
☐	ZOFRAN		IV
☐	Other:		
☐	Other:		

LABS

SELECT	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.