SHERIDAN COMMUNITY HOSPITAL
OUTPATIENT INFUSION CENTER
PHONE: 989.291.6295 FAX: 877.249.1191

☐ **STAT REFERRAL**

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** ☐ **MEDIPORT** ☐ **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
☐	BENADRYL				
☐	COMPAZINE				
☐	DEPACON				
☐	DHE 45				
☐	DILANTIN				
☐	KEPPRA				
☐	KETOROLAC				
☐	METHYLPREDNISOLONE				
☐	METOCLOPRAMIDE				
☐	ORPHENADRINE				
☐	PROMETHAZINE				
☐	VYEPTI	100 mg	IV	Once Every 3 Months	
☐	VYEPTI	300 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.