Center for Infusion Care

HILLSDALE HOSPITAL

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				
	DEPAKOTE				
	DHE 45				
	DILANTIN				
	KEPPRA				
	KETOROLAC				
	METHYLPREDNISOLONE				
	METOCLOPRAMIDE				
	ORPHENADRINE				
	PROMETHAZINE				
	VYEPTI	100mg	IV	Once Every 3 Months	
	0.9% NS				

PREMEDS

SELECT BELOW	MEDICATION	DOSE	ROUTE
	NONE	NA	NA
	BENADRYL	50mg	IV
	ACETAMINOPHEN		
	OXYGEN		
	ZOFRAN		IV
	Other:		
	Other:		

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.