Southwestern Medical Center
Empowered by ScionHealth

Phone: 580-531-4892
Fax: 877-249-1191

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES

HEADACHE ORDER FORM

☐ STAT REFERRAL

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 BELOW	MEDICATION	DOSE	ROUTE
	NONE	NA	NA
	BENADRYL		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.