IVHEALTH CENTER

Fax:_____Phone:_____

Name _____

DOB_____ **ID#**_____

Weight _____ **Date** _____

Migraine Therapy

Diagnosis: (ICD-10 code) _____ - Description_____

For Provider

(Circle all that apply)

- Request macronutrients lab test
- Request CBC
- Request BMP
- Request G6pd deficiency (Required for any infusion involving vitamin C)

Infusion Medication

(Please circle)

- 1 gram MgSO4 in 50ml 0.9 NS or 2 gram MgSO4 in 100ml 0.9 NS
- Infuse over 1 hour

Pre-Meds

If no pre medications needed please leave blank

- _____
- _____
- _____
- _____
- _____

Additional Orders

Provider Signature: _____ **Date:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____