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Dihydroergotamine (DHE) Referral Form

Please fax the following information to **(360) 933-1197** to facilitate a swift and easy referral:

DEMOGRAPHICS

Patient Name: _____ Date of Birth: _____

Home Phone: _____ Cell: _____ Work: _____

Address: _____

City: _____ State: _____ Zip: _____

FINANCIAL INFORMATION: Please fax a copy of front and back of all insurance cards if available.

ORDERS Height: _____ Weight: _____ Allergies: _____

Diagnosis: _____ ICD-10: _____

Infusion Orders: Duration of therapy: 3 days 5 days Other: _____

Dihydroergotamine (DHE):

Infuse 0.5 mg (test dose) IV, then repeat 1 hour later if tolerated. Stop therapy if hypertension, severe nausea, or chest pain occur. Then infuse 1 mg 8 hours later, and every 8 hours (intranasally at night).

Other instructions: _____

Metoclopramide:

Infuse 10mg IV via peripheral line by slow IV push over at least 2 minutes every 8 hours, 30 minutes before each DHE dose. (Patient will premedicate nighttime intranasal DHE dose with PO metoclopramide.)

May increase dose to 20 mg if severe nausea occurs.

Other instructions: _____

Ondansetron: 8mg IV every 6 hours as needed for nausea, or _____

Prochlorperazine: 10 mg IV every 4 hours as needed for nausea (max 4/day), or _____

Other Medication: _____

- ◆ Alteplase 2mg IV to de clot central IV access per Infusion Solutions protocol as needed for occlusion.
- ◆ Flush line with D5W, 0.9% NaCl and/or Heparin 10 units/ml or 100 units/ml per Infusion Solutions protocol.
- ◆ Lidocaine 1% - up to 0.2ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).
- ◆ Infusion Reaction Management per Infusion Solutions protocol as needed.

Nursing Orders:

◆ If no central IV access, RN to insert peripheral IV, rotate site as needed.

Other: _____

Lab Orders:

_____ every _____

 Prescriber Signature

 Date

 Please Print Name