Infusion Solutions Inc.
Home Infusion & Specialty Pharmacy
477 W. Horton Rd
Bellingham, WA 98226
Phone (360) 933-4892
Fax (360) 933-1197

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 declot 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