



Migraine Order

Phone: (346) 708-5160

Fax: (888) 963-8103

www.biotekrx.com

PATIENT INFORMATION		PRESCRIBER INFORMATION	
Patient Name:		Prescriber Name:	
Address:		State License:	NPI#
City, State, Zip:		DEA:	Phone:
Phone:	2 nd Phone:	Address:	Fax:
DOB:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		City, State, Zip:
Weight:	Ht:	Date:	Contact Person:
ICD-10 code:	Diagnosis:		Phone:
Allergies:			

PREMEDICATION		
<input type="checkbox"/> Solu-Medrol 125 mg IVP		
<input type="checkbox"/> Zofran 4 mg SIVP	<input type="checkbox"/> Zofran 8 mg SIVP	<input type="checkbox"/> Phenergan 25 mg IM
<input type="checkbox"/> Toradol 30 mg IVP	<input type="checkbox"/> Pepcid 20 mg IV	<input type="checkbox"/> Benadryl 25 mg IV
<input type="checkbox"/> Toradol 60 mg IVP	<input type="checkbox"/> Tylenol 325 mg PO	<input type="checkbox"/> Benadryl 25-50 mg PO

MEDICATION	
<input type="checkbox"/> Depacon IV 500 mg IV x 1	<input type="checkbox"/> Depacon IV 1000 mg IV x 1
<input type="checkbox"/> IV Fluids _____	<input type="checkbox"/> IV Fluids _____
<input type="checkbox"/> Mag Sulfate IV 1 gm IV	

SIGNATURE	
X _____	Date: _____
(Product Substitution Permitted)	

CONFIDENTIALITY STATEMENT: This facsimile and documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited.

If you have received this information in error, please notify the sender at the address and telephone number set forth herein and arrange for return or destruction of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.

Fax completed form to: (888) 963-8103 - Thank you for using BioTek reMEDys®