Holland Hospital

AMBULATORY TREATMENT UNIT

Migraine Headache Infusion Order Set

Phone (616) 394-3547
Fax (616) 394-2139

☐ = Optional Order • = Routine Order (cross out and initial **bulleted orders** that do not apply.)

ORDERS

Date: _____ **Time:** _____ **Diagnosis Code: (ICD-10)** _____

Patient Name: _____ **Date of Birth:** _____ **Weight:** _____ (kg)

Allergies: _____

IV FLUIDS

☐ Normal Saline 0.9% IV 1 liter. Run over 1 hour.
☐ Other:

MEDICATIONS

☐ Diphenhydramine Dose _____ Route _____ Frequency _____
☐ Prochlorperazine Dose _____ Route _____ Frequency _____
☐ Dihydroergotamine Dose _____ Route _____ Frequency _____
Patient has been screened for no triptans the last 24 hours.
☐ Dexamethasone Dose _____ Route _____ Frequency _____
☐ Magnesium Dose _____ Route _____ Frequency _____
☐ Orphenadrine Dose _____ Route _____ Frequency _____
☐ Promethazine Dose _____ Route _____ Frequency _____
IVP route is not available per hospital policy.
☐ Ketorolac ☐ 15mg IVP ☐ 30mg IVP Frequency _____
☐ Methylprednisolone Dose _____ Route _____ Frequency _____
☐ Valproic Acid Dose _____ Route _____ Frequency _____
No Tricyclic for 72 hrs.
This medicine requires a negative pregnancy test for all patients of childbearing age.
☐ Zofran Dose _____ Route _____ Frequency _____

Treatment for Adverse Drug Reactions (*for mild to moderate infusion reaction*)

- Slow or stop infusion for 20 minutes
- Give:
  - Diphenhydramine (Benadryl) 25 mg slow IVP STAT (may repeat times 1)
  - Acetaminophen (Tylenol) 650 mg PO STAT, if not already given as a "premedication". *(Maximum acetaminophen doses of 4000 mg in 24 hours from all combined sources.)*
  - Methylprednisolone (Solu-Medrol) 125 mg IVP STAT
- Place O_2 PRN at 4 – 6 liters per nasal cannula STAT
- Vital signs with PO_2 every 5 minutes until stable
- Notify the physician of reaction. Request further orders as indicated.
- Complete adverse drug reaction PowerForm and document in the allergy profile for all drug reactions.

☑ **By signing this order, patient has been screened for triptan use and pregnancy, if applicable.**

Provider Signature: _____ Date: _____

Provider Name and Credentials (please print): _____ Time: _____

Office Phone: _____ Office Fax: _____