Ondansetron for Hyperemesis Gravidarum (HG) Referral Form

Fax this completed form with clinical documentation to 734-470-0777

1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Name:	Physician Name:
Address:	License #:
City State Zip	NPI#: DEA#:
Home phone: Mobile:	Address:
Email:	City: State: Zip:
DOB: SSN:	Office contact:
Gender: HT: Weight:	Phone: Fax:
LMP: EDD:	

3. DIAGNOSIS ICD10:

4. Please send the following with this referral: ☒Labs ☒Patient Demographics
☒Copies of front and back of all insurance cards ☒Supporting clinical documentation

Allergies: ☐ **NKDA**

☐ Okay to substitute product ☐ DAW: Use only Zofran

☐ Intermittent SubQ: 4mg-8mg every 6 hours via pump. Maximum of 32mg/24 hours
Administer undiluted

☐ Intermittent IV: 4mg-8mg every 6 hours via pump. Maximum of 32mg/24 hours
Infuse each dose over 15 minutes
Please provide central line placement report for IV administration

☐ Continuous IV ***OR*** ☐ Continuous Subcutaneous

1. Start at 1mg/hour (24mg/day) Titrate based on patient response to keep the dosage range at 12-32mg/day)0.5mg/hr-1.332mg/hr)
2. In the event of episodic nausea and vomiting, administer up to two demand bolus doses per 24 hour period. Bolus doses can range from 0.5 to 2mg per 24 hour period.
3. Use Curlin 6000 in PCA mode for IV or SC

Please provide central line placement report for IV administration

MONITOR: weight, oral and IV intake, frequency of NVP, constipation, response to therapy, adverse drug effects, pump malfunctions.

Length of therapy:

Lab orders: ☐CBC with diff ☐BMP ☐CMP ☐LFT ☐Other: _____
☐Weekly ☐Every other week ☐Other:_____

Other:

Physician Signature _____ Date _____

Form updated 10.30.25

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