Fax: 614-929-7199 | Phone: 614-929-3349| Email: info@infuseoneohio.com

(Haloperidol)

Haldol orders

INFUSE ONE

Patient Name _____ DOB _____

Phone Number _____ M ____ F _____

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Schizophrenia ☐ _____Tourette's Disorder

☐ _____ Other

PRE-MEDICATIONS (optional)

☐ Acetaminophen 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ _____ (other)

☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ _____ (other)

Haldol (Haloperidol) ORDERS

DOSAGE & FREQUENCY

☐ **Initial**: _____ IM once
(10-20 times the patients daily oral dose. Max initial dose 450mg)

☐ **Maintenance**: _____ IM every 4 weeks
(10-15 times the patients daily oral dose. Max dose 450mg every 4 weeks)

☐ _____ Other

Patient Weight
_____ lbs
_____ kg

ORDERING PROVIDER

Signature _____ Phone_____Fax_____

Provider _____ Date _____