4004657509-621

Allergy
Clinical Order Form

Name:
DOB:

906/ALL

Labs: Bayview (for DACI, QUEST, LabCorp, use specialized form) ☐ **See specialized form**

	CBC with Diff and platelets		**T4**		**Total serum IgE**		
	Basic Metabolic Panel		**TSH**				
	Comp Metabolic Panel		**C1 esterase inhibitor**				
	Hepatic Panel		**C3, C4**				
	ALT, AST		**Urinalysis Complete**				
	CRP		**WESR**				

Radiology: ***See stickers for where to send patient, if American or Advanced, document on separate form also.***

Imaging:
- ☐ **CT Sinus without Contrast**
- ☐ **Chest CT - *Contrast?* Y / N , *High Resolution?* - Y / N**
- ☐ **Chest XRay PA and Lateral**
- ☐ **Other _____, - *Contrast?* - Y / N**

PFT: ☐ **Spirometry** ☐ **Flow Volume Loops** ☐ **DLCO** ☐ **HeLV**

☐ **Spirometry Pre and Post w/ Bronchodilator - *Can patient receive Albuterol?* Y / N** **if Yes, fill out Albuterol Inhaler med order below*

Clinic Orders: ***Use specialized forms for all***

☐ **Skin Test (*Prick / ID*)** ☐ **Challenge – Oral / Parenteral _____** ☐ **Desensitization** ☐ **Spirometry (on unit)**

☐ **Spirometry Pre and Post w/ Bronchodilator - *Can patient receive Albuterol?* Y / N** **if Yes, fill out Albuterol Inhaler med order below*

☐ **Immunotherapy** ☐ **Other: _____**

Order	Drug	Dose	Route	Time
	Tuberculin PPD	0.1 ml	Injection Intradermal	Today
	Influenza Vaccine	0.5 ml	Injection Intramuscular	Today
	Pneumovax/Pneumococcal Vaccine	0.5 ml	Injection Intramuscular	Today
	Xolair/Omalizumab	___ mg	Injection Subcutaneous	Visits per month: ____ Injections per visit:____
	Nebulizer - Albuterol	2.5 mg	Inhalation	Today Frequency
	Nebulizer - Atrovent/ Ipratropium Bromide	0.5 mg	Inhalation	Today Frequency
	*Albuterol ProAir Inhaler	___ puffs	Inhalation	10 min before PFT post test

Consults/Referrals: **To** _____ ☐ **Routine** ☐ **Urgent** ☐ **Before next visit**

To _____ ☐ **Routine** ☐ **Urgent** ☐ **Before next visit**

Return Visit/Follow Up: _____**Weeks**_____**Months** **Date:**_____

ICD-9 Codes: (numeric) _____ **Attending:** _____

Ordered By: Printed_____**MD Signature**_____ **BVMD#** _____**Date/Time:**_____

Date	Time	Initials	Printed Name:	Signature:	Date	Time	Initials	Printed Name:	Signature:

4/17/12 RLC / EK

4004657589-629

PATIENT EVALUATION FORM

ATTENDING PHYSICIAN: FELLOW:

VITALS: BP: _____ Temp: _____ HR: _____ Resp: _____ Peak 1: _____ Peak 2: _____ Peak 3: _____

HISTORY OF PRESENT ILLNESS

GENERAL APPEARANCE: [ ] NORMAL [ ] ABNORMAL SPECIFY:

SKIN: [ ] NORMAL [ ] ABNORMAL SPECIFY:

HEENT: [ ] NORMAL [ ] ABNORMAL SPECIFY:

NECK: [ ] NORMAL [ ] ABNORMAL SPECIFY:

LUNGS: [ ] NORMAL [ ] ABNORMAL SPECIFY:

HEART: [ ] NORMAL [ ] ABNORMAL SPECIFY:

ABDOMEN: [ ] NORMAL [ ] ABNORMAL SPECIFY:

EXTREMITIES: [ ] NORMAL [ ] ABNORMAL SPECIFY:

ASSESSMENT & PLAN

DICTATION # PHYSICIANS NAME & SIGNATURE:

☐ Continuation Sheet