



Allergy Clinical Order Form

Name: _____
DOB: _____

906/ALL

| | | | | | |
|--------------------------------------------------------------------------------------------------------------|-----------------------------|-----------------------|-----------------|--|--|
| Labs: Bayview (for DAPI, QUEST, LabCorp, use specialized form) <input type="checkbox"/> 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: |
|------|------|----------|---------------|------------|------|------|----------|---------------|------------|
| | | | | | | | | | |
| | | | | | | | | | |



4004657509-629

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

DICTIONATION #

PHYSICIANS NAME & SIGNATURE: