**PATIENT INFORMATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Referral Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Desired Treatment Start Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: Weight(kg): Pt Contact #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diagnosis:**

* Clinical Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD-10 Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication/Nursing Care Orders (select all that apply):**

* Cortrosyn 0.25mg, IM
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_
* Order Duration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Completion Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
*

**Standing Orders:**

* Reaction management protocol initiation for hypersensitivity/ anaphylactic reaction.

BBC Emergent Management of Anaphylaxis in Adults #PHY037 version 05/15/21

**Laboratory Orders (Check all that apply);**

* Control sample of blood to be drawn in a plain, red top tube or serum gel tube before the injection of Cortrosyn
* Second blood sample to be collected in a plain, red top tube or serum gel tube 60 minutes after the injection of Cortrosyn
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Test to be done in the morning

**Additional Orders/Plan of Care Instructions:**

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**PROVIDER INFORMATION**

Referring Practice:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone/Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Name (Print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| **Fax completed treatment plan to:** **Beartooth Billings Clinic Outpatient Services** **Fax:406-815-6667** **Phone: 406-446-0563 406-446-0565****IF OUTSIDE OF BILLINGS CLINIC PROVIDER GROUP:****Please include patient demographics/insurance information, current medication list, lab/test results as applicable and most recent provider documentation related to prescribed treatment plan.**  |

* Our team will confirm receipt of referral to the contact listed above.
* Treatment documentation will be viewable in Cerner if within Billings Clinic Provider Group, faxed upon completion to all other referring providers.
* Change in patient’s baseline status and/or initiation of reaction protocol will be immediately reported to the referring provider.
* If collecting lab series**, please provide preferred means for relaying results and/or desired parameters required to proceed and/or withhold treatment**. If not specified, treatment will be either held or given as directed based on current ***Wolters Kluwer/Up To Date*** administration guidelines.

***Thank you for allowing us to participate in your patient’s care-***

**Beartooth Billings Outpatient Services.**