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

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

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

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

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

**Diagnosis (select one):**

* G35 Relapsing Remitting Multiple Sclerosis
* Other: Clinical Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

* Natalizumab (Tysabri) 300mg in 100mL Sodium Chloride 0.9%, IV, to infuse over 1 hour, once every 4 weeks
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Order Duration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Completion Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* PICC line in place (If marked, please include insertion documentation)
* PICC Dressing Change Weekly on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Remove PICC on the last day of treatment? Yes No

**Pre-Treatment Medications to be administered 30 minutes prior to treatment (Check/Complete all that apply):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Acetaminophen
 | * 500mg
 | * 650mg
 | * 1000mg
 | * PO
 |
| * Diphenhydramine
 | * 25mg
 | * 50mg
 | * PO
 | * IV
 |
| * Methylprednisolone
 | * 40mg
 | * 125mg
 | * IV
 |  |
| * Famotidine
 | * 20mg
 | * PO
 | * IV
 |  |
| * Other:
 |

**Pre-Treatment Requirements (Check if completed. Provide supporting documentation if outside of Billings Clinic Provider Group):**

* Anti-JCV antibody results prior to start of therapy and within 6 months

**Standing Orders:**

* Reaction management protocol initiation for hypersensitivity/ anaphylactic reaction.

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

* Monitor patient for 1 hour post-infusion

**Laboratory Orders;**

* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Interval\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

|  |
| --- |
|  |

**PROVIDER INFORMATION**

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

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

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

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

|  |
| --- |
| **Fax completed treatment plan to:** **Beartooth Billings Clinic Outpatient Services** **Fax:406-815-6667** **Phone: 406-446-0563 or 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.**