

Patient Name _____
 DOB _____
 MRN _____
 Physician _____
 FIN _____

Defaults for orders not otherwise specified below:

- Interval: Every 28 days
- Interval: Every ___ days

Duration:

- Until date: _____
- 1 year
- _____ # of Treatments

Anticipated Infusion Date _____ ICD 10 Code with Description _____

Height _____ (cm) Weight _____ (kg) Allergies _____

Provider Specialty

- | | | | |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Allergy/Immunology | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> OB/GYN | <input type="checkbox"/> Rheumatology |
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Internal Med/Family Practice | <input type="checkbox"/> Other | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Nephrology | <input type="checkbox"/> Otolaryngology | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Genetics | <input type="checkbox"/> Neurology | <input type="checkbox"/> Pulmonary | <input type="checkbox"/> Wound Care |

Site of Service

- | | | | |
|--|--|---------------------------------------|---|
| <input type="checkbox"/> SH Gerber | <input type="checkbox"/> SH Lemmen Holton (GR) | <input type="checkbox"/> SH Pennock | <input type="checkbox"/> SH United Memorial |
| <input type="checkbox"/> SH Helen DeVos (GR) | <input type="checkbox"/> SH Ludington | <input type="checkbox"/> SH Reed City | <input type="checkbox"/> SH Zeeland |

Appointment Requests

- Infusion Appointment Request**
 Status: Future, Expected: S, Expires: S+365, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after, Infusion

Provider Reminder

- ONC PROVIDER REMINDER**
 For symptoms of allergic reaction or anaphalaxis, order "Peds Hypersensitivity Reactions" Therapy Plan.

Provider Ordering Guidelines

- ONC PROVIDER REMINDER 26**
 Dose of omalizumab is based on pretreatment IgE level and body weight. Dose should be adjusted for significant changes in body weight. If therapy has been interrupted for greater than or equal to 1 year, total IgE level should be re-evaluated for dosing determination.

Lab Orders

	Interval	Duration
<input type="checkbox"/> _____	<input type="checkbox"/> Every ___ days <input type="checkbox"/> Once	<input type="checkbox"/> Until date: _____ <input type="checkbox"/> 1 year <input type="checkbox"/> _____ # of Treatments
<input type="checkbox"/> _____	<input type="checkbox"/> Every ___ days <input type="checkbox"/> Once	<input type="checkbox"/> Until date: _____ <input type="checkbox"/> 1 year <input type="checkbox"/> _____ # of Treatments

Pre-Medications

- Pre-medication with dose: _____
- Pre-medication with dose: _____

CONTINUED ON PAGE 2 →

NOTE: Epic Treatment/Therapy Plan Orders. To be scanned/attached to the appropriate Infusion Referral Order in Epic.

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

