**Student Health and Wellness Services**

**Allergy Immunotherapy Orders**

**Patient Name: Date of Birth:**

**In order to administer antigens to your patient listed above, the following information on both pages must be completed before we are able to proceed. We cannot administer allergy injections until all information on this form has been provided and signed by the patient’s physician.**

1. Antigen injection schedule that includes: Name, dosage and frequency of antigens to be given including minimum number of days between injections.
2. Antigen vials labels must include: Patients name, contents, concentration, expiration date
3. Copy of most recent antigen treatment record including documentation of reactions. If there was no reaction, please indicate that on the record.
4. MANAGEMENT OF MISSED INJECTIONS according to number of days from LAST injection given. Please provide instructions to cover a 4-6-week period.
5. During Build-Up phase

\_\_\_\_ to \_\_\_\_ days – Repeat previous dose

\_\_\_\_ to \_\_\_\_ days – Decrease dose by \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ to \_\_\_\_ days – Decrease dose by \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ to \_\_\_\_ days – Decrease dose by \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ to \_\_\_\_ days – Decrease dose by \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ to \_\_\_\_ days – Decrease dose by \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ to \_\_\_\_ days – Decrease dose by \_\_\_\_\_\_\_\_\_\_\_

1. After Reaching Maintenance Dose

\_\_\_\_ to \_\_\_\_ days – Repeat previous dose

\_\_\_\_ to \_\_\_\_ days – Decrease dose by \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ to \_\_\_\_ days – Decrease dose by \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ to \_\_\_\_ days – Decrease dose by \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ to \_\_\_\_ days – Decrease dose by \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ to \_\_\_\_ days – Decrease dose by \_\_\_\_\_\_\_\_\_\_\_

1. Maintenance protocol for buildup of fresh antigens (Student Health Services protocol is to reduce the dosage of fresh antigens by 50%)

Increase dose by \_\_\_\_\_ ml every \_\_\_\_ days until maintenance is reached.

**Student Health and Wellness Services**

**Allergy Immunotherapy Orders**

**Patient Name: Date of Birth:**

1. Dose adjustment for local reactions

(If you do not have preprinted instructions for dosage adjustments, please complete table below)

Repeat dose if swelling is > \_\_\_\_\_ mm and < \_\_\_\_\_ mm

Reduce dose by \_\_\_\_\_ ml if swelling is > \_\_\_\_\_ mm and < \_\_\_\_\_ mm

Reduce dose by \_\_\_\_\_ ml if swelling is > \_\_\_\_\_ mm and < \_\_\_\_\_ mm

Reduce dose by \_\_\_\_\_ ml if swelling is > \_\_\_\_\_ mm and < \_\_\_\_\_ mm

Reduce dose by \_\_\_\_\_ ml if swelling is > \_\_\_\_\_ mm and < \_\_\_\_\_ mm

1. Is patient required to have taken an antihistamine prior to injections? YES NO
2. Has the patient experienced previous significant local or systemic reactions to antigens? YES NO
	1. If yes, please describe reaction to which antigen & tx \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. When should patient return to your office for evaluation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Unless you provide other instructions, patients will be required to wait in our building for 20 minutes after receiving their antigen injections.
3. We will contact your office for further instructions if necessary. This will be followed by a form faxed to your office documenting the situation with a request for signed orders by the allergist and returned to us. We will not be able to proceed with your patient’s allergy injections until we receive the form completed in its entirety.

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| **Physician (print name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_****Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |