Engle Center for Counseling and Health Services

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Allergen Immunotherapy Order Form

For your patient's safety and to facilitate the transfer of allergy treatment to our clinic, this form must be completed to provide standardization and prevent errors. Failure to complete this form will delay or prevent the patient from utilizing our services. Form can be delivered by the patient, mailed, or faxed (see address and fax above).

Patient Name: _____ Date of Birth: _____

Physician: _____ Office Phone: _____ Secure Fax:_____

Office Address: _____

PRE-INJECTION CHECKLIST:

- Is peak flow required prior to injection? NO ☐ YES: ☐ **If yes**, peak flow must be **≥** _____L/min to give injection.
- Is student required to have taken an antihistamine prior to injection? NO ☐ YES ☐

INJECTION SCHEDULE: Date of Last Doses and Reaction Noted_____

Begin with _____ (dilution) at _____ml (dose) and increase according to the schedule below.

Dilution					
Vial Cap Color					
Expiration Date(s)	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	Go to next Dilution	*Go to next Dilution*	*Go to next Dilution*	*Go to next Dilution*	ml

MANAGEMENT OF MISSED INJECTIONS: (According to number of days from ***LAST*** injection)

During Build-Up Phase	***After Reaching Maintenance***
▪ ___ to ___ days – continue as scheduled	▪ ___ to ___ days – give same maintenance dose
▪ ___ to ___ days – repeat previous dose	▪ ___ to ___ weeks – reduce previous dose by _____ (ml)
▪ ___ to ___ days – reduce previous dose by _____ (ml)	▪ ___ to ___ weeks – reduce previous dose by _____ (ml)
▪ ___ to ___ days – reduce previous dose by _____ (ml)	▪ Over ___ weeks – contact office for instructions
▪ Over _____ days – contact office for instructions	

REACTIONS:

At next visit: Repeat dose if swelling is >_____mm and <_____mm.

Reduce by one dose increment if swelling is >_____mm.

Other Instructions: _____

_____

Physician Signature: _____ Date: _____