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MESSIAH UNIVERSITY

Allergen Immunotherapy Order Form

For your patient's safety and to decrease the risk of errors for our students, we have created a standardized Allergen Immunotherapy Order Form that we utilize for every patient seen in our allergy clinic. Failure to complete this form will delay or prevent the patient from utilizing our services. The form can be delivered by the patient, mailed, or faxed (see address and fax above). Please complete the form in its entirety. "See attached" is not sufficient, and we will not be able to provide allergy injections until we receive this information.

Patient Name:______________________________ Date of Birth: ______________________________

Physician: ______________________ Office Phone: ________________ Secure Fax: _____________

Office Address:____

PRE-INJECTION CHECKLIST

- Is peak flow required prior to injection? ☐ NO ☐ YES ≥ ___________ L/min to give injection
- Is student required to have taken an antihistamine prior to injection? ☐ NO ☐ YES

INJECTION SCHEDULE: Date, amt and reaction of last dose________________________

Begin with ___________(dilution) at ____________ ml (dose) and increase according to the schedule below.

***"See attached" is NOT acceptable for schedule information.**

(If additional spaces are needed or alternative regimens are used, please cross out this section and complete schedule on back.)

Vial #/Cap Color					
Dilution					
Expiration Date	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
	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
	ml	ml	ml	ml	ml
	Go to next dilution	Go to next dilution	Go to next dilution	Go to next dilution	Maintenance

INJECTION INTERVAL: ***DAYS FROM LAST INJECTION*** – *"See attached" **is NOT acceptable** for interval instructions.

Build-up	**Maintenance**
___ to ___days: Continue as scheduled	___to___days: Continue maintenance dose
___ to ___days: Repeat previous dose	___to___days: Reduce dose by _____(mL)
___ to ___days: Reduce previous dose by ______ (mL)	___to___days: Reduce dose by _____(mL)
___ to ___days: Reduce previous dose by ______(mL)	___to___days: Reduce dose by _____(mL)
Over _____days: Contact office for instructions	___to___days: Contact office for instructions

MANAGEMENT OF LOCAL REACTIONS:

At next visit: **Repeat dose** if swelling is > _____mm and lasts longer than _____ hours.
Reduce dose by _______ if swelling is > _____mm.

Other Instructions:____

____

Physician Signature: ____Date:______________

Extended or Alternative Regimen Schedule (Optional)

Vial #/ Cap Color							
Dilution							
Vial Contents							
Expiration Date	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
	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	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	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	ml	ml	ml	ml	ml