Towson University Health Center
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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. Allergy serum cannot be sent to the Health Center directly. Our packages go to the main University loading dock and we cannot guarantee the temperature will be appropriate for the serum. The serum must be sent to the student directly.

*Please note that we require patients to wait in the office for 30 minutes after receiving an allergy injection. Additionally, if we have any questions about the serum or dose and are unable to reach your office for a consult, we will not give the patient their injection.

Patient Name: _____ Date of Birth: _____
Allergist Name: _____
Office Address: _____
Office Phone: _____ Secure Fax: _____
Business Days/Hours: _____

Pre-Injection Checklist:

Does the patient have a history of anaphylaxis? Y / N
Does the patient have a history of asthma? Y / N
Is peak flow required prior to injection? Y / N If yes, peak flow must be Ó_____ L/min to give injection.
Is the patient required to premedicate with an antihistamine prior to the injection? Y / N
Is switching arms/injection sites required? Y / N

Injection Schedule:

Last injection: was _____ ml of _____vial/dilution, administered on _____ date (including reaction) as follows: _____

Next injection: Begin with _____ dilution/vial at _____ ml (dose) and increase according to the schedule below. Injections during the build-up phase should be administered every _____ days.

Vial Name/#:	_____	_____	_____	_____
Vial Cap Color:	_____	_____	_____	_____
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

Once the patient reaches _____ml, they should begin the next dilution.
Does patient need to return to the allergy office for administration of the first dose of a new vial? Y / N
Maintenance dose is _____ml of _____ dilutio

Management of Local Reactions:

a. Negative: Raised wheal up to ____mm, proceed according to schedule
b. Wheal ____ to ____mm, repeat previous dose
c. Wheal ____ to ____mm, reduce by _____
d. Wheal >____mm, contact the allergy office
e. Additional instructions: _____
_____

Management of Missed/Late Injections:

Build-up Phase:

a. If ____ days or less since last injection, proceed as scheduled

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Immunotherapy Check List and Contract

	YES	NO
1. Immunotherapy schedule of patientôs orders complete	☐	☐
2. Vials of serum labeled with:		
Patientôs Name & DOB or TU ID#	☐	☐
Expiration date (MM/DD/YYYY)	☐	☐
Bottle Number or ID code	☐	☐
3. Appointment schedule reviewed	☐	☐
4. Billing/Payment/Fees discussed with patient	☐	☐
5. Discussion of patientôs responsibility for obtaining new orders(by fax or in writing) if needed	☐	☐
6. Patientôs phone number/demographics are up to date	☐	☐
7. Contract reviewed by patient and provider	☐	☐

_____ _____

(Patient Signature) (Date)

_____ _____

(Provider Signature) (Date)