





Towson University Health Center Phone: (410) 704-2466 | Fax: (410) 704-3715

## **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. Date of Birth: Patient Name: 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 Ki'{ gu.'r gcmhny 'o ww'dg''x 'aaaaaaa 'Nlo kp''y i kxg'kplgevkqp0 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 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 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





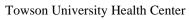
| Manage  | ement of Local Reactions:                                     |  |  |
|---------|---|--|--|
| a.      | Negative: Raised wheal up tomm, proceed according to schedule |  |  |
| b.      | Wheal tomm, repeat previous dose                              |  |  |
| c.      | Wheal tomm, reduce by   |  |  |
| d.      | Wheal >mm, contact the allergy office                         |  |  |
| e.      | e. Additional instructions:                                   |  |  |
|         |   |  |  |
|         |   |  |  |
| Manage  | ement of Missed/Late Injections:                              |  |  |
| Build-u | p Phase:  |  |  |
| a.      | If days or less since last injection, proceed as scheduled    |  |  |





## **Immunotherapy Check List and Contract**

| 1.  | Ko o wpqyj gtcr { "uej gf wrg"qh"r cwlgp wu'qtf gtu"eqo r rgwg     | YES<br>□ | NO |
|-----|--|----------|----|
| 2.  | Vials of serum labeled with:                                       |          |    |
|     | Rcvkgpvøu"P co g"( "FQD"qt"VW"F %                                  |          |    |
|     | Expiration date (MM/DD/YYYY)                                       |          |    |
|     | Bottle Number or ID code   |          |    |
| 3.  | Appointment schedule reviewed                                      |          |    |
| 4.  | Billing/Payment/Fees discussed with patient                        |          |    |
| 5.  | F kuewuukqp"qh"r cvkgpv/xu"t gur qpukdkrkx{ "hqt "qdvckpkpi "pgy " |          |    |
|     | orders(by fax or in writing) if needed                             |          |    |
| 6.  | Pcvkgpvøu'r j qpg'pwo dgt lf go qi tcr j keu''ctg''wr ''vq''f cvg  |          |    |
| 7.  | Contract reviewed by patient and provider                          |          |    |
|     |  |          |    |
| (Pa | tient Signature)   | (Date    | *) |
| (Pr | ovider Signature)  | (Date    | e) |





Phone: (410) 704-