





Allergen Immunotherapy Order Form

For your patient's safe provide standardizatio our services. Allergy s loading dock and we c student directly. *Please note that we r	on and prevent errors. It serum cannot be sent to cannot guarantee the te equire patients to wait	Failure to complete to the Health Center emperature will be a in the office for 30	this form will dela directly. Our pack appropriate for the minutes after rece	y or prevent the patier ages go to the main U serum. The serum mu iving an allergy inject	nt from utilizing (niversity st be sent to the ion.	
Additionally, if we ha		t the serum or dose	and are unable to r	each your office for a	consult, we	
will not give the patier	•	D				
	Patient Name:		Date of Birth:			
Allergist Name:						
Office Address:						
	Office Phone:		Secure Fax:			
Business Days/Hours:	· . <u></u>					
Pre-Injection Checklist:						
Does the patient have	a history of anonhylar	r_{10} V / N				
Does the patient have						
Is peak flow required	•		<u></u>	aaa"Nia lo'ya'i laa'ini	contran0	
Is the patient required					gewypo	
Is switching arms/inje	-	-	of to the injection?	1 / 1		
is switching arms/mje	ction sites required?	1 / IN				
Injection Schedule:						
Last injection: was	ml of .	vial/dilution_admin	istered on	date (including	reaction) as	
follows:		viai/dilution, admin			reaction) as	
Next injection: Begin with _	dilutic	n/vial at	ml (dose) and in	crease according to the	e schedule below	
Injections during the b				-	e senedule below.	
injections during the t	und-up phase should		ury 0	ays.		
Vial Name/#:						
Vial Cap Color:		<u> </u>				
Expiration Date:						
	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	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



Immunotherapy Check List and Contract

1.	Ko o wpqyjgtcr{'uejgfwng''qh'rcwlgpwou''qtfgtu''eqorngwg	YES □	NO □			
2.	Vials of serum labeled with:					
	• Rcvkgpvøu'P co g'('F QD'qt''VW'KF %					
	• Expiration date (MM/DD/YYYY)					
	• Bottle Number or ID code					
3.	Appointment schedule reviewed					
4.	Billing/Payment/Fees discussed with patient					
5.	Fkuewuukqp"qh'rcvkgpvøu't gurqpukdkrkv{ 'hqt 'qdvckpkpi 'pgy "					
	orders(by fax or in writing) if needed					
6.	5. Pcvkgpvøu'r j qpg''pwodgt lf goqitcr j keu''ctg''wr ''vq''f cvg					
7.	Contract reviewed by patient and provider					

(Patient Signature)

(Provider Signature)

(Date)

(Date)



Towson University Health Center Phone: (410) 704-