JAMES MADISON UNIVERSITY HEALTH CENTER

724 S. Mason St. MSC-7901, Harrisonburg, VA 22807
Secure FAX: 540-568-6176.

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: JMU Student Date of Birth: 1/1/1996
Physician: Dr Guertler Office Phone: 540-568-6178 Secure Fax: 540-568-6176
Office Address: 724 South Mason St. Harrisonburg, VA 22807

PRE-INJECTION CHECKLIST:

- Is peak flow required prior to injection? NO ☐ YES: ☑ **If yes**, peak flow must be ≥ 300 L/min to give injection.
- Is student required to have taken an antihistamine prior to injection? NO ☑ YES ☐

INJECTION SCHEDULE:

Begin with 1:10,000 (dilution) at 0.1 ml (dose) and increase according to the schedule below.

Dilution	1:10,000	1:1000	1:100	1:10	1:1
Vial Cap Color	Silver	Green	Blue	Yellow	Red
Expiration Date(s)	12/31/19	12/31/19	12/31/19	12/31/19	12/31/19
	0.1 ml	0.1 ml	0.1 ml	0.1 ml	0.05 ml
	0.2 ml	0.2 ml	0.2 ml	0.2 ml	0.1 ml
	0.3 ml	0.3 ml	0.3 ml	0.3 ml	0.15 ml
	0.4 ml	0.4 ml	0.4 ml	0.4 ml	0.2 ml
	0.5 ml	0.5 ml	0.5 ml	0.5 ml	0.25 ml
	— ml	— ml	— ml	— ml	0.3 ml
	— ml	— ml	— ml	— ml	0.35 ml
	— ml	— ml	— ml	— ml	0.4 ml
	— ml	— ml	— ml	— ml	0.45 ml
	Go to next Dilution	*Go to next Dilution*	*Go to next Dilution*	*Go to next Dilution*	0.5 ml

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

During Build-Up Phase	*After Reaching Maintenance*
▪ 2 to 10 days – continue as scheduled	▪ 7 to 13 days – give same maintenance dose
▪ 11 to 15 days – repeat previous dose	▪ 2 to 3 weeks – reduce previous dose by 0.1 (ml)
▪ 16 to 20 days – reduce previous dose by 0.1 (ml)	▪ 4 to 5 weeks – reduce previous dose by 0.2 (ml)
▪ 21 to 30 days – reduce previous dose by 0.2 (ml)	▪ Over 5 weeks – contact office for instructions
▪ Over 30 days – contact office for instructions	

REACTIONS:

At next visit: Repeat dose if swelling is > 25 mm and < 50 mm.
Reduce by one dose increment if swelling is > 50 mm.

Other Instructions: Note dosage schedule change for Red Vial

Physician Signature: ____________________ Date: ____________

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