**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: Date of Birth:

Physician: Office Phone: Secure Fax:

Office Address:

**PRE-INJECTION CHECKLIST:**

* Is student required to have epi-pen with them at time of injection? NO YES
* Is student required to have taken an antihistamine prior to injection? NO YES

**INJECTION SCHEDULE :**

Begin with \_\_\_ (dilution) at \_\_\_ml (dose) and increase according to the schedule below.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Dilution** |  |  |  |  |  |
| **Vial Cap Color** |  |  |  |  |  |
| **Expiration Date(s)** |  / / . |  / / . |  / / . |  / / . |  / / . |
|  | 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* | ml |
|  |  |  |  |  |  |

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

|  |  |
| --- | --- |
| *During Build-Up Phase* | *After Reaching Maintenance* |
| * to days – continue as scheduled
 | * to days – give same maintenance dose
 |
| * to days – repeat previous dose
 | * to weeks – reduce previous dose by \_\_\_\_\_ (ml)
 |
| * to days – reduce previous dose by \_\_\_\_\_\_ (ml)
 | * to weeks – reduce previous dose by \_\_\_\_\_ (ml)
 |
| * to days – reduce previous dose by \_\_\_\_\_\_ (ml)
 | * Over weeks – contact office for instructions
 |
| * Over \_ days – contact office for instructions
 |  |

**REACTIONS:**

*At next visit:* Repeat dose if swelling is > mm and < mm.

Reduce by one dose increment if swelling is > mm.

Other Instructions: ­­\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature: Date: