OFFICE OF STUDENT LIFE
STUDENT HEALTH CENTER
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Referring Allergist Agreement

The Indiana University Student Health Center Allergy Clinic now serves over 130 student patients referred by different allergy specialists. Each allergy specialist has a unique form they use in their office. As you can imagine, navigating different forms is very challenging and has significant potential for error. Therefore, to maximize the safety margin for all student patients, our clinic has developed our own Allergen Immunotherapy Administration Form that we will utilize for every student patient in our allergy clinic.

Referring Allergist Agreement

My patient is requesting Indiana University Student Health Center (SHC) administer allergy extracts provided by my office.

I agree to the following:

- I will provide allergen immunotherapy extract in adequately labeled vials for administration at SHC. This includes:
  - **Patient name**
  - **Patient DOB**
  - **Antigen name**
  - **Dilution**
  - **Expiration date**
- I will provide detailed directions by **completely** filling out the Allergen Immunotherapy Order Form provided by SHC.
- Injections will not be provided if this form is not completed. **"See attached documents" will not be accepted.**
- I understand that verbal orders for allergy serum doses are not accepted. These must be faxed.
- I will continue to be responsible for the management of this patient's immunotherapy and for the modification of doses during therapy.
- I will be available by phone to the nurses and providers at SHC should questions or problems arise with this patient's immunotherapy
- I understand that SHC requires all patients to have an Epi Pen with them in order to receive their allergy injections.

Provider Name: _____ Date: _____

Provider Signature: _____