DIVISION OF STUDENT AFFAIRS
**STUDENT HEALTH CENTER**
600 N Jordan Ave, Bloomington, IN 47405
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# Allergen Immunotherapy Order Form

For the safety of your patient and to facilitate a timely transition to our health center, this form must be completed any time there is a change in orders or new vials are received. **Your patient CANNOT receive their injections at our facility until this form has been completed and received by fax or mail.**

| | |
|---|---|
| Patient Name: | Date of Birth: |
| Allergist: | Office: |
| Address: | |
| Phone: | Fax |

## PRE-INJECTION

Is peak flow required prior to injection? NO ☐ YES ☐ **Hold injection if < _____L/min**

Is student required to take an antihistamine prior to injection? NO ☐ YES ☐

Can student receive a vaccine the same day as an allergy injection? NO ☐ YES ☐

## INJECTION SCHEDULE:

Begin with _____(dilution) at _____ ml(dose) and increase according to the schedule below. Increase according to schedule every _____ to _____days/weeks. Once maintenance dose of _____ml is reached, repeat every _____ to days/weeks.

***Please indicate at what vial/dose NEW serum should be ordered: _____.**

| Dilution/Color: | | | | | | |
|---|---|---|---|---|---|---|
| Expiration: | | | | | | |
| | 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 | 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** | **Go to next dilution** | **Maintenance** |

*If patient has an extended or complicated build schedule use the "Extended Build-Up Schedule"

## MISSED INJECTIONS:

| During Build-Up Phase | | After Reaching Maintenance | |
|---|---|---|---|
| | Continue as scheduled | | Continue as scheduled |
| | | | |
| | | | |
| | | | |
| | **Contact office for instructions** | | **Contact office for instructions** |

## REACTIONS:

| | |
|---|---|
| | Continue as scheduled |
| | |
| | |
| | |
| | **Call office for instructions** |

## Additional Instructions:

_____

_____

**Physician Signature:** **Date:**

*By signing this form you attest that you have read our Allergist Agreement and reviewed the Allergy Clinic Policies and Procedures.