OFFICE OF STUDENT LIFE
STUDENT HEALTH CENTER

Xolair Injection Order Form

PATIENT INFORMATION

Name	Date of Birth
Allergies	
Patient Phone #	
Diagnosis/ICD10 Code	

PRESCRIPTION INFORMATION

DRUG NAME AND STRENGTH	DIRECTIONS
_____ DATE OF LAST ADMINISTERED DOSE	Dose Route Site Frequency

ORDER VALID

FROM	UNTIL

Can injection be given early or late? Yes No

Parameters for late injection: _____

_____

How long does patient need to carry epi-pen post injection? _____

VITAL SIGNS

Required pre-administration Yes No

Required post-administration Yes No

Parameters for Vital Signs:

Blood Pressure _____

Temperature _____

Respirations _____

Pulse Ox _____

Does patient need monitored post-injection? Yes No

How long should patient be monitored? _____

Immunization and Travel Clinic phone (812) 855-7514 fax (812) 856-8729

ADDITIONAL INSTRUCTIONS

Are there any important tasks that need to be done prior to each injection (i.e. weight check, lab work, etc.):

PRESCRIBER INFORMATION

Signature		Date
Name		Credentials
Address		
City	State	Zip
Phone	Fax	

NOTE: THIS ORDER IS NOT VALID UNLESS ALL FIELDS ARE COMPLETED.

A new form needs to be submitted each year in order for your patient to continue to receive injections at our facility. The form can be found on the SHC's website under Therapeutic Injections.

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