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 peak flow required prior to injection? NO [ ] YES [ ] If yes, peak flow must be > ______ L/min to give injection.
- Is student required to have taken an antihistamine prior to injection? NO [ ] YES [ ]
- Is patient required to carry EpiPen at the time of allergy injections? NO [ ] YES [ ]

INJECTION SCHEDULE:

ROUTE: Subcutaneous (SQ) [ ]

***Must complete a separate order form for each Vial Contents***

Vial Contents: __________________________

Begin with __________________________ (dilution) at _________ ml (dose) and increase according to the schedule below.

<table>
<thead>
<tr>
<th>Dilution</th>
<th>Vial Cap Color</th>
<th>Expiration Date(s)</th>
<th>Frequency</th>
<th>MAINTENANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vial Cap Color</td>
<td>Expiration Date(s)</td>
<td>Frequency</td>
<td></td>
<td></td>
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<tr>
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</tr>
</tbody>
</table>

Go to next Dilution

Go to next Dilution

Go to next Dilution

Go to next Dilution

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

<table>
<thead>
<tr>
<th>During Build-Up Phase</th>
<th>After Reaching Maintenance</th>
</tr>
</thead>
<tbody>
<tr>
<td>___ to ___ days – continue as scheduled</td>
<td>___ to ___ days – give same maintenance dose</td>
</tr>
<tr>
<td>___ to ___ days – repeat previous dose</td>
<td>___ to ___ days/weeks – reduce previous dose by ____(ml)</td>
</tr>
<tr>
<td>___ to ___ days – reduce previous dose by ____ (ml)</td>
<td>___ to ___ days/weeks – reduce previous dose by ____ (ml)</td>
</tr>
<tr>
<td>___ to ___ days – reduce previous dose by ____ (ml)</td>
<td>Over ___ days/weeks – contact office for instructions</td>
</tr>
<tr>
<td>Over ___ days – contact office for instructions</td>
<td><em><strong>Please circle days or weeks</strong></em></td>
</tr>
</tbody>
</table>

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Revised: 06/28/2018
Management and Dosage Adjustment for Localized Reactions:

Less than ______ mm…………………………………………………………….Proceed to next scheduled dose
Greater than ______ mm…………………………………………………………….Repeat same dose for next injection
Greater than ______ mm…………………………………………………………….Reduce by one dose for next injection
Greater than ______ mm…………………………………………………………….Reduce by two doses for next injection

Other Instructions (e.g., call allergist for further instructions, etc.):

________________________________________________________

REACTIOnS: (PLEASE CHECK ALL THAT APPLY)

Local Reactions (soreness, redness, itching, or swelling at injection site)
- [ ] apply cold compress to the injection site
- [ ] give an analgesic (pain reliever) for soreness
- [ ] give antipruritic (anti-itch) medication
  - Oral antihistamine (e.g., Zyrtec, Diphenhydramine)
  - Topical Corticosteroid (e.g. Hydrocortisone 1% Anti-itch Cream)

Systemic Reactions [sudden or gradual onset of generalized itching, erythema (redness), or urticaria (hives), angioedema (swelling of the lips, face, or throat), severe bronchospasm (wheezing), shortness of breath, shock, abdominal cramping, nausea/vomiting, or cardiovascular collapse]

- [ ] Patient to be evaluated IMMEDIATELY by the SHC physician at first sign of any of these symptoms.
- [ ] First-line treatment: Administer aqueous epinephrine 1:1000 dilution intramuscularly to the THIGH muscle, 0.01mL/kg/dose (adult dose ranges from 0.3 mL to 0.5 mL, with maximum dose of 0.5mL).
- [ ] Optional treatment: H₁ antihistamines for hives or itching; you may also administer diphenhydramine (either orally or by intramuscular injection; the standard dose is 1-2 mg/kg every 4-6 hrs, up to 50 mg maximum single dose).
- [ ] If no improvement, repeat dose of Epinephrine every 5-15 minutes for up to 3 doses, depending on patient’s response and activate the Emergency Medical System (EMS; e.g., call 911).
- [ ] Notify the patient’s Allergist/Immunologist as soon as possible.

Other Instructions: ____________________________________________________________

________________________________________________________

Physician Signature: ___________________________ Date: __________________________