UT DALLAS STUDENT HEALTH CENTER

800 W. Campbell Rd., SSB 43, Richardson, TX 75080
PHONE: 972-883-2747 FAX: 972-883-2069

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.

					MAINTENANCE
Dilution					
Vial Cap Color					
Expiration Date(s)	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
Frequency					
	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	ml	ml	ml	ml
		Go to next Dilution	ml	ml	ml
			Go to next Dilution	ml	ml
				Go to next Dilution	ml
					ml

MANAGEMENT OF MISSED INJECTIONS: (According to # 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____days/weeks – reduce previous dose by _____(ml)
▪ ____to_____days – reduce previous dose by_____(ml)	▪ ____to ___ days/weeks – reduce previous dose by_____(ml)
▪ ____to_____days – reduce previous dose by_____(ml)	▪ Over_____days/weeks – contact office for instructions
▪ Over____ days – contact office for instructions	*****Please circle days or weeks*****

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Patient Name:_____ **Date of Birth**: _____

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……._____

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**: **H_1 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: _____

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