# 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 below).

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 the student required to have taken an antihistamine prior to injection? ☐ NO ☐ YES

**INJECTION SCHEDULE:**

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

The initial injection MUST be given at the allergist office. Redfern Health Center will not administer accelerated build-up schedules.

**Set A**

Vial Contents: _____

| **Dilution** | | | | | |
|---|---|---|---|---|---|
| **Site** | | | | | |
| **Vial Cap Color** | | | | | |
| **Expiration Date(s)** | ____/____/____ | ____/____/____ | ____/____/____ | ____/____/____ | ____/____/____ |
| | 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* | ml |

CLEMSON STUDENT HEALTH SERVICES
LIVE WELL. LEARN WELL.

Please visit our website at *clemson.edu/studenthealth.*

REDFERN HEALTH CENTER
CS006: 5/22
Box 344054, Clemson, SC 29634-4054
P: 864-656-2233 F: 864-656-0760
DIVISION OF STUDENT AFFAIRS

Attribution-NonCommercial-ShareAlike 4.0 International (CC BY-NC-SA 4.0) This document is licensed under the Creative Commons Attribution-NonCommerical-Share Alike 4.0 International license: https://creativecommons.org/licenses/by-nc-sa/4.0/ "

**Set B**

Vial Contents: _____

| **Dilution** | | | | | |
|---|---|---|---|---|---|
| **Site** | | | | | |
| **Vial Cap Color** | | | | | |
| **Expiration Date(s)** | ____/____/____ | ____/____/____ | ____/____/____ | ____/____/____ | ____/____/____ |
| | 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* | ml |

*Use additional sheets if more than 2 sets of injections*

**MANAGEMENT OF MISSED INJECTIONS:** (According to number of days from ***LAST*** injection)
*Allergy injections will not be given if three months or longer has passed since the last documented injection(s).

The patient will need to return to their allergist's office for a new dosing schedule and first injection(s) of the dosing schedule.

| ***During Build-Up Phase*** | ***After Reaching Maintenance*** |
|---|---|
| ____ to _____ days: continue as scheduled | ____ to _____ days: give same maintenance dose |
| ____ to _____ days: repeat previous dose | ____ to ____ weeks: reduce previous dose by _____ (ml) |
| ____ to _____ days: reduce previous dose by _____ (ml) | ____ to _____ weeks: reduce previous dose by _____ (ml) |
| ____ to _____ days: reduce previous dose by _____ (ml) | over _____ weeks: contact office for instructions |
| over _____ days: contact office for instructions | |

**LOCAL REACTIONS:**

*At next visit:* Repeat dose if swelling is >_____mm and <_____mm.
Reduce by one dose increment if swelling is >_____mm.

**SYSTEMIC REACTIONS:**

Symptoms of systemic reactions include, but are not limited to itching of the skin, urticaria, faintness, flushing, coughing, perspiration, nausea, vomiting, pallor, cyanosis, a "thick throat", tightness of the chest, feeling of impending doom and frank collapse.

**Should a systemic reaction occur**: Immediately give 1:1000 Epinephrine IM. An antihistamine can be given along with an H2 medication such as Zantac and a dose of Prednisone according to Redfern Health center Care physician's order. In a more serious reaction, also use oxygen at 2-3 liters, have IV fluids and repeat Epinephrine dose if needed by Redfern Health Center Urgent Care physician's order.

Other Instructions: _____

_____

Physician Signature: _____ Date: _____