University of New Hampshire

Health & Wellness
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Allergy Immunotherapy Order Form

H&W 712.2

For your patient's safety and to facilitate the transfer of allergy treatment to our clinic, this form must be completed for each immunotherapy to provide standardization and prevent errors. We do not accept allergy immunotherapy patients with greater than 4 allergy injections to be given in one visit. Failure to complete this form will delay or prevent the patient from utilizing our services. This completed form may be delivered by the patient, mailed, or faxed. (see address & fax above)

Patient Name: _____ Date of Birth: _____

Physician: _____ Office Phone: _____ Secure Fax: _____

Office Address: _____

Date/Amount of last injection: _____

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 patient required to have taken an antihistamine prior to injection? No☐ Yes☐
- Is the patient required to have an Epi Pen? No☐ Yes☐

COMPLETE ONE FORM FOR <u>EACH</u> VIAL/ALLERGEN

Injection Schedule:

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

Contents of Vial/ Concentration					
Vial 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
	Go to next dilution	Go to next dilution	Go to next dilution	Go to next dilution	ml

Or: If at maintenance: _____dilution at _____ml dose at _____interval.

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 ____ 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	

Reactions:

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

Other Instructions: _____

_____

Physician Signature: _____ Date: _____