University of New Hampshire

Health & Wellness
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Allergy Immunotherapy Order Form

For your patient's safety and to facilitate the transfer of allergy treatment to our clinic, this form must be **completed in full** 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 **all sections** on 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 EACH 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: ___________________

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