PLEASE FILL OUT THE FORM BELOW COMPLETELY. INCOMPLETE FORMS WILL BE RETURNED.

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 four 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 to (603) 862-4259.

Patient Name: ____ Date of Birth: ________________________

Physician: ____________________________ Office Phone: ______________ Secure Fax: ______________

Office Address: ____

Date/Amount of last injection: ____

Pre-Injection Checklist:

- Is the patient required to have taken an antihistamine before 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 the next dilution	Go to the next dilution	Go to the next dilution	Go to the next dilution	ml

Or: If at maintenance: __________dilution at ______ml dose at ___________________interval.

Health & Wellness
4 Pettee Brook Lane
Durham, NH 03824

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 the same maintenance dose
____ to ____ days – repeat the 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: ________________________

Policy /Form 712.2

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