LAFAYETTE
BAILEY HEALTH CENTER

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Allergen Immunotherapy Order Form

For your patient's safety and to facilitate the transfer of allergy treatment to our clinic, this form must be fully 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: _____

Provider: _____ 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.
- Has the patient had a systemic reaction in the past? NO_____ YES_____
- Does the patient have a history of asthma? NO_____ YES_____ Does the patient use an inhaler? NO_____ YES_____
- Is the patient required to carry an Epinephrine Auto-Injector to receive allergy injections? NO_____ YES_____
- Is student required to have taken an antihistamine prior to injection? NO_____ YES_____ List medication_____
- Rotate injections sites? NO_____ YES_____

INJECTION SCHEDULE:

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

Dilution					
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

MANAGEMENT OF MISSED INJECTIONS: (According to number 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 – reduce previous dose by _____ (ml)
▪ ___ to ___ days – reduce previous dose by _____ (ml)	▪ ___ to ___ days – reduce previous dose by _____ (ml)
▪ ___ to ___ days – reduce previous dose by _____ (ml)	▪ Over ___ days – 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.

Physician Signature: _____ Date: _____