Student Health Center
Frostburg State University
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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 completed to provide continuation of care and to prevent errors. **Failure to complete this form will delay or prevent the patient from utilizing our services**. Forms can be delivered by email or fax. (email and fax information above)

Patient Name: _____ Date of Birth: _____

Physician: _____ Office Phone: _____ Secure Fax:_____

Office Address: _____

PRE-INJECTION CHECKLIST:

Is the patient required to take an antihistamine prior to injection? 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 ___ 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	

REACTION DIRECTIONS:

Local

Systemic

Physician Signature: _____ Date: _____