University of Mary Washington
Student Health Center, Lee Hall, Room 112
1301 College Avenue
Fredericksburg, VA 22401-5300

Office: (540) 654-1040
Fax: (540) 654-1077
web:
students.umw.edu/healthcenter
Email: healthcenter@umw.edu

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 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: ______________________

Physician: _____________________________ 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.
- Is student required to have taken 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
	Go to next Dilution	ml	ml	ml	ml
		Go to next Dilution	ml	ml	ml
			Go to next Dilution	ml	ml
				Go to next Dilution	ml
					ml

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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