ALLERGY IMMUNOTHERAPY ORDER FORM

Purdue University Student Health Services
601 Stadium Mall Drive.
West Lafayette, IN 47907

Phone: 765-494-1818
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PATIENT INFORMATION

Patient Name: _____ Patient DOB: _____

Patient Phone: _____

Allergist Name: _____

Facility Name: _____

Facility Address:
City, State, Zip _____

Facility Phone: _____ Facility Fax: _____

Phone Number for Late Instructions (Office patient receives injections & hours): _____

Phone & Fax Number for Mixing Office (If different than above): _____

_____

PRE-INJECTION ORDERS

(If not checked, it will not be expected for patient to have completed prior to Injection at PUSH)

☐ Peak Flow Must be > _____ L/min to give injection. (Pt to bring with them to appointment).

☐ Antihistamine prior to injection (to be taken by patient **prior** to arriving at PUSH).

INJECTION SCHEDULE/BUILDUP SCHEDULE

∗Date of last injection: _____ Vial(s) and Dose(s) given: _____

Begin with _____ dilution at _____ ml (dose) and increase according to the enclosed schedule every _____ days/weeks until a maximum tolerated dose of _____can be achieved, then repeat every _____.

When should serum be reordered: _____ Does patient need to contact you? ☐ Y ☐ N

∗Reactions

Repeat dose if swelling is > _____ mm and < _____ mm.

Reduce by _____ if swelling is > _____ mm.

∗Rebuilding *after missed injections or reactions (otherwise we will follow the above schedule).*

Pt is to return every _____ days, increasing by _____ ml until _____.

Extracts should be shipped:
(All extracts are shipped Mon-Tues-Weds from PUSH as Next Day delivery with tracking number available)

☐ No Ice
☐ On Ice

Physician Signature: _____ Date: _____