HEALTH SERVICES
Student Services
SETON HALL UNIVERSITY
Phone: 973-761-9175 Fax: 973-761-9193

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. This form can be delivered by the patient, mailed, or faxed to our office.

Patient Name_____ Date of birth_____

Ordering Allergist_____ Office phone_____ Fax_____

Office address_____

I. PRE-INJECTION CHECKLIST

Is peak flow required prior to injection? NO / YES If yes, peak flow must be >_____to give injection.
Is the patient required to take an antihistamine prior to injection? NO / YES
Is the patient required to have an EpiPen at the time of injection? NO / YES
Length of time patient must wait in office following injection _____

II. INJECTION SCHEDULE – COMPLETE ONE FORM FOR EACH VIAL/ANTIGEN

Date of last injection_____ Dose of last injection _____

Begin with _____ (dilution) at _____ml and increase every _____according to schedule below:

Dilution					
Contents					
Color Vial					
Exp date	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
	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	Go to next dilution

III. MANAGEMENT OF MISSED INJECTIONS (according to number of days since LAST injection)

During *Build Up* phase	**After reaching maintenance**
____ to ____ days continue as scheduled	____ to ____ days give same dose
____ to ____ days repeat previous dose	____ to ____ weeks reduce by ____ ml
____ to ____ days reduce by ____ ml	____ to ____ weeks reduce by ____ ml
Over ____ days- contact office for instructions	

IV. REACTIONS (instructions for next visit)

Repeat dose if wheal is >_____ mm and < _____ mm Reduce dose by one increment if wheal is >_____ mm

Other instructions: _____

Allergist Signature: _____ **Date: _____**