University of North Texas Student Health and Wellness Center

Address: 1800 Chestnut St, Denton, TX 76201

Phone: (940) 565-2333 Fax: (940) 369-7042

REQUEST FOR ALLERGY IMMUNOTHERAPY ORDERED BY NON-CAMPUS HEALTH SERVICE PHYSICIAN

PHYSICIAN AGREEMENT (PLEASE PRINT)

Patient Name & Student ID: _____Date of Birth: _____

Allergist Name: _____

The above patient has requested the UNT Student Health and Wellness Center give him/her/them allergen immunotherapy ordered by you. We are pleased to do this in the capacity of an agent for you. To ensure the health and safety of our patients, we require the following from you:

1) The UNT Immunotherapy administration form **MUST BE** completed correctly, completely and provided to the allergy clinic prior to a patient receiving injections. We **WILL NOT** accept "see attached" which refers us to use your office form(s).
2) Every student's initial injection(s) must be given by the prescribing allergist.
3) Mixing and diluting extract must be done by the prescribing allergist. We are not responsible for shipping serum back should it need adjustment.
4) Allergy extracts must be properly labeled with patient name, date of birth, antigen content, concentration, and the expiration date.
5) A signed Immunotherapy injection log is required for each vial.
6) All orders must be signed by the allergist. We do not accept verbal orders for any adjustments that need to be made.
7) Your office supplies the medication(s) and we supply disposable syringes and needles. We are not responsible for breakage or loss of medication during transit.
8) Agreements/orders will be updated on an annual basis.

After all the above has been received, it will be reviewed by our Director of Clinical Services. If accepted, you will receive a fax with instructions to mail serum to our physical address (1800 Chestnut Street, Denton, TX 76201) via Fed Ex of UPS only.

Please keep in mind, during times such as semester and summer breaks, if your patient will not be at UNT they will need to plan accordingly. We will provide the patient with a copy of his/her/their immunotherapy record, if requested, when he/she/they return to your care.

Thank you,

UNT Student Health and Wellness Center

Responsible Allergist's Name (please print): _____

Responsible Allergist Signature: _____

Date Signed: _____

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ADMINISTRATION FORM (PLEASE PRINT)

For your patient's safety and to facilitate the transfer of allergy treatment to our clinic, this form MUST BE completed in full to provide standardization and prevent errors. Please do not write "See Enclosed Instructions." Failure to complete this form will delay or prevent the patient from utilizing our services. Form can be delivered by the patient or faxed.

Patient Name: _____ Date of Birth: _____

PRE-INJECTION CHECKLIST:

Patient ☐ needs to carry epi-pen day of injection ☐ does not need to carry epi-pen

Patient ☐ rotate arms ☐ given in same arm

Patient ☐ needs 02 sat prior ☐ hold if below_____

Patient ☐ needs peak flow prior to injection ☐ does not need peak flow

☐ baseline peak flow _____ ☐ hold if peak flow <_____

Patient ☐ needs to pre medicate with _____

☐ does not need to premedicate

INJECTIONS

BUILD UP PHASE	MAITENANCE PHASE
Must have _____ days between injections	Maintenance dose is _____ mL every _____ days or _____ weeks and must have at least _____ days between doses.
• ___ to____ days - continue as scheduled	• ___ to____ days - give same maintenance dose
• ___ to____ days - repeat previous dose	• ___ to____ days - reduce dose by ____ (mL)
• ___ to____ days - reduce dose by ____ (mL)	• ___ to____ days - reduce dose by ____ (mL)
• ___ to____ days - reduce dose by ____ (mL)	• ___ to____ days - reduce dose by ____ (mL)
• Over _____ days contact office for instructions	• Over _____ days contact office for instructions
	NEW MAINTENACE DOSE
	• Drop back _____ doses from previous vial
	• Increase by ____ mL every _____ days
	• No more than _____ days between an increased dose.

Name: _____ Date of Birth: _____

REACTIONS

At next Visit: Repeat dose if swelling is >_____ mm and <_____ mm.

Reduce by _____ mL if swelling is >_____mm.

Has the patient experienced previous significant local or systemic reactions to allergy extracts?

☐ Yes ☐ No

If YES, indicate type of reaction, which extract(s) and previous treatment for adverse reaction:

_____

_____

Illness: _____ (specify illness)

☐ Withhold ☐ decrease dose by _____mL

Wheezing: ☐Withhold ☐ecrease dose by _____mL

Increased allergy symptoms: ☐ Withhold ☐ decrease dose by _____mL

Increased asthma symptoms: ☐ Withhold ☐ decrease dose by _____mL

Use of antibiotics: ☐ Withhold ☐ may receive allergy injection(s)

Beta-Blocker: Is patient taking any Beta-Blockers? ☐ Yes ☐ No

Is the Beta-Blocker taken PRN? ☐ Yes ☐ No

Allergy injections will not be administered by SHWC if the patient has taken a Beta-Blocker (such as Propranolol) within the 24 hours prior to their allergy injection.

Other instructions: _____

_____

NOTE: A 30-minute waiting time after immunotherapy administration will be enforced per SHWC policy.

_____ _____

Allergist Signature Street Address

_____ _____

Allergist's Name (please print) City State Zip Code

(_________)________________________________

Fax Number

(_________)________________________________

Telephone Number

Name: ____

Date of Birth: _________________________

Allergist: _____________________________________

Allergist Signature: _________________________

Vial: _____ Dilution: ______________ Exp Date: ________

Vial: _____ Dilution: __________ Exp Date: ________

Date	Dilution	Dose	Arm	Reaction	Initials		Date	Dilution	Dose	Arm	Reaction	Initials

Injector Signature	Initials