UVA | Department of Student Health and Wellness

Allergen Immunotherapy Order Form

550 Brandon Ave Charlottesville VA, 22908 Fax: (434) 243-6691

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: _____ Office Address: _____ Secure Fax: _____

Pre- Injection Checklist:

- Is peak flow required prior to injection? Y/N: ___ If yes, peak flow must be > __ L/min to give injection.
- Is student required to carry an epinephrine auto injection? Y/N___
- Is student required to have taken an antihistamine prior to injection? Y/N__

Injection Schedule:

Begin with _____ (dilution/dose). Increase according to the schedule every ___ to ___ days/weeks. Once maintenance does is reached, repeat every __ weeks.

Dilution	1:10,000	1:1,000	1:100	1:10	1:1 Maintenance
Expiration	__/__/_____	__/__/_____	__/__/_____	__/__/_____	__/__/_____
	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
					Go to next dilution

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	

Reactions:

At next visit: Repeat dose if swelling is > ___ mm and < ___ mm Reduce by one dose increment if swelling is >____mm.

ICD Codes: _____
Physician Signature: _____ Date:_____

Updated 5.2023