WAKE FOREST UNIVERSITY STUDENT HEALTH SERVICE

Information needed for Allergy Injection Clinic:

Patient Name_____ **DOB** ___/___/___ **Student ID** _____

To: Allergy Physician:

The Wake Forest Student Health Service looks forward to working with you and your patient. To help us better serve your patient, and to maximize safety, we require the attached **PHYSICIAN ORDER FOR ALLERGY IMMUNIOTHERAPY** be completed and signed for each allergy serum before we can continue allergy injections. This form will decrease the chance of miscommunication and resultant allergy administration errors.

Please complete the following information for your patient:

1. Does your patient have a history of Asthma? **YES / NO**
2. History of Anaphylaxis? **YES / NO**
3. Does your patient use antihistamine prior to receiving allergy injections**?** **YES / NO**
4. Do you require a Peak Flow prior to injections**?** **YES / NO** If **YES**, peak flow must be > _____L/min
5. A mandatory wait time will be enforced after injections. Do you require a **20 or 30** minute wait?

Please note:

- Every patient's initial injection(s) must be performed at the Allergist's office.
- Each vial must be clearly labeled with the patient's name, dilution and expiration date.
- No expired serum will be administered.
- New allergy serum vials must be sent directly to the patient, NOT the Student Health Service
- Allergy injections will not be administered in the Student Health Service without a physician being in the clinic.
- For any systemic reactions, Epinephrine (1:1000) is given IM 0.3 IM, in anteriolateral thigh, and if hives or itching of skin/mucosal membrane or runny nose are present, Diphenhydramine (Benadryl) 50mg is given IM in the deltoid. The allergist's office will be notified of the event and request further instructions and orders.

MD Signature_____ Date _____

Printed MD Name _____

We look forward to working with you and your office in providing care for your Wake Forest student.

Sincerely,

Joanne Clinch, MD
Clinical Director

Kathy Carstens, BSN, RN,BC
Director of Nursing

WAKE FOREST UNIVERSITY STUDENT HEALTH SERVICE

1834 Wake Forest Rd, Campus Box 7386, Winston Salem, NC 27109
Phone: 336-758-5218 Fax: 336-758-6054

PHYSICIAN ORDER FOR ALLERGY IMMUNIOTHERAPY

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 may 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:_____Practice Name:_____

Office Phone:_____Fax:_____

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

Allergy Vials

Vial	Vial contents	Last dose given	Dilution of vial	Date of last dose
Example: Vial A	*Cat, Dog, Grass*	*0.3*	*1:100*	*5/1/18*

INJECTION SCHEDULE:

	Frequency of injections
BUILD UP:	Every _____ days
MAINTENANCE:	Every _____days or _____weeks

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_____weeks – 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: **Proceed** with next dose if swelling is < _____mm
Repeat next dose if swelling is > _____mm and < _____mm
Reduce next dose by _____ml if swelling is > _____mm
Call the office if >_____mm or systemic reaction.

Other Instructions: _____

_____

_____

Physician Signature: _____Date: _____

Office Address: _____

The Wake Forest Student Health Service nursing staff will call your office for any clarifications in orders prior to giving injections.