WAKE FOREST
UNIVERSITY
Deacon Health

Dear Allergist,

Wake Forest University Deacon Health 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 IMMUNOTHERAPY** 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 note:

- Patient's initial injection(s) must be performed at an Allergist's office.
- Each vial must be clearly labeled with the patient's name, dilution and expiration date.
- Each Vial must list all materials in the serum.
- No expired serum will be administered. Exceptions may be made if explicit instructions are provided on the order form (i.e. Okay to use serum one month beyond expiration date without need for further consultation with my office)
- New serum vials to be sent directly to the patient, NOT Deacon Health.
- For any systemic reactions, Epinephrine (1:1000) is given IM.
- If hives or itching of skin/ mucosal membranes or runny nose are present, Diphenhydramine 50 mg is to be administered IM.
- The allergist office will be notified of the event and a request for further instructions and orders.
- No injections will be given if the patient is ill, febrile, wheezing, has an upper respiratory infection, or has hives or an unknown rash.
- Allergy injections will only be administered in Deacon Health when a provider is in the clinic. Rarely, a physician will not be on site, and advanced practice providers will be available to assist your patient with any concerns that occur with administration of the serum.

Exclusion criteria

- Patients on a beta-blocker or MAOI
- Deacon Health reserves the right to discontinue this service and refer back to you for management should any safety concerns develop while under care.

Physician Order for Allergy Immunotherapy

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. This form can be delivered by the patient, mailed, or faxed (see address and fax below).

Patient Name: _____ Date of Birth: _____
Physician: _____ Practice Name: _____
Office Phone: _____ Fax: _____

Pre-Injection Checklist

- Does your patient have a history of Asthma? **YES ❑ NO ❑**
- History of Anaphylaxis? **YES ❑ NO ❑**
- Does your patient use antihistamine prior to receiving allergy injections? **YES ❑ NO ❑**
- Do you require a Peak Flow prior to injections? **YES ❑ NO ❑**
    - If **YES**, Peak flow must be >_____ L/min
- A mandatory wait time will be enforced after injection.
    - Do you require a **20 ❑ or 30 ❑** minute wait?

Allergy Vials

Vial	Vial Contents	Last Dose Given	Dilution of Vial	Date of Last Dose
Ex: Vial A	Cat, Dog, Grass	0.3	1:100	5/1/2022

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 – continues 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: _____

Wake Forest University Deacon Health clinical staff will call your office for any clarifications in orders prior to giving injections.