WAKE FOREST
Deacon Health

Dear Allergist Office,

Wake Forest University Deacon Health is glad to work with you to continue allergy shots for your patient while they are enrolled at Wake Forest. To ensure safe treatment, please complete the attached **"Provider Order for Allergy Immunotherapy"** form in its **entirety.**

We must receive this form before treatment can continue. **Incomplete forms will be returned for correction, which may delay your patient's care.** Please note that any orders written on your office paperwork but not included on the Deacon Health form **will not be followed.**

Fax the completed form to Deacon Health at 336-758-6054.

Please review the following important requirements:

- The patient's first allergy injection(s) must be given at an allergist's office.
- Each vial must be clearly labeled with the patient's name, date of birth, dilution, expiration date, and the specific allergens included.
- Expired serum will not be used unless clearly approved on the order form (for example, "okay to use up to one month past expiration").
- We cannot use treatment plans, notes, or orders from outside offices if they say "see attached" or reference their own paperwork rather than our order set.
- Deacon Health clinical staff will give injections subcutaneously without aspiration.
- If a serious allergic reaction occurs, epinephrine 0.3 mg will be given as an intramuscular injection.
- Patients must bring a current, non-expired epinephrine auto-injector to every visit. If they do not have it with them, the injection will not be given. Please make sure your patient has an active prescription.
- If a systemic reaction occurs, the allergist's office will be notified. No further injections will be given until the patient is reevaluated and new orders are received and approved.
- Injections will not be given if the patient is sick, has a fever, is wheezing, has a respiratory infection, or has hives or an unexplained rash.
- Allergy injections are only given when a medical provider is on site. This may be a physician or an advanced practice provider.

Exclusion criteria

- Patients on a beta-blocker or monoamine oxidase inhibitor (MAOI).
- Deacon Health may stop providing this service and refer the patient back to your office if any safety concerns arise during care

Sincerely,
Deacon Health

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Provider Order for Allergy Immunotherapy

For your patient's safety and to help transfer their allergy treatment to our clinic, this form must be completed. It helps keep care consistent and reduces the risk of errors.
If the form is not completed, your patient's treatment may be delayed or may not be able to continue with our services. The form can be sent with the patient, mailed, or faxed (see address and fax number below).

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

Pre-Injection Checklist:

- Does your patient have a history of asthma? **YES** ❑ **NO** ❑
- History of anaphylaxis? **YES** ❑ **NO** ❑
- Do you require your patient to take an 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.
- Length of time the patient must remain in the clinic after injection: _____ minutes.
- Alternate arm with each injection? **YES** ❑ **NO** ❑

Allergy Vials:

Vial	**Vial Contents (Allergens)** ***Do not use abbreviations***	**Vial Dilution**	**Last Dose Given (mL)**	**Date of Last Dose**
Ex: Vial A	Cat, Dog, Grass	1:100	0.3	5/1/2022

Injection Schedule:

	Frequency of Injections
Build Up	Every _____ days.
Maintenance	Every _____ days or _____ weeks.

Management of Missed Injections: (according to time elapsed since ***LAST*** injection)

During Build-Up	**During Maintenance**
____ to ____ days – continue as scheduled	____ to ____ weeks: give same maintenance dose
____ to ____ days – repeat previous dose	____ to ____ weeks: reduce dose by _____
____ to ____ days – reduce previous dose by _____	____ to ____ weeks: reduce dose by _____
____ to ____ days – reduce previous dose by _____	____ to ____ weeks: reduce dose by _____
Over ____ days: contact office for instructions	Over ____ weeks: contact office for instructions

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Student Name:_____ DOB:_____

Dilution					
Vial Cap Color					
	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
	mL	mL	mL	mL	**Maintenance**
	mL	mL	mL	mL	**Dose will be:**
	Next dilution	Next dilution	Next dilution	Next dilution	mL

Maintenance New Vial Instructions: _____

_____

_____

Reactions:
At next visit:

Repeat previous dose if swelling is > _____mm.
Reduce previous dose by _____ if swelling is >_____ mm.
Reduce previous dose by _____ if swelling is >_____ mm.
Call the office if swelling >_____ mm or for systemic reaction.

Other Instructions: ***SEE ATTACHED** will not be acknowledged as orders; please list other orders below

_____

_____

_____

☐ I acknowledge that I have reviewed Deacon Health's requirements for allergy immunotherapy and agree with the procedures for this patient.

Provider Signature: _____ Date: _____

Office Address: _____