Elon University

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Elon, NC 27244

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**REQUEST FOR ALLERGY IMMUNOTHERAPY ORDERED BY NON-STUDENT HEALTH SERVICES PHYSICIAN**

**TO PATIENT:**

Student Health Services desires to assist you in receiving allergy immunotherapy ordered by a non-Student Health Services physician while you are a patient here. We must have detailed information and instructions from your physician regarding this condition and covering all circumstances that may arise. It is your and your physician’s responsibility to supply the medication(s) to be used. Immunotherapy **will not be given if instructions are inadequate**. **We cannot be responsible for breakage, improper shipping, or loss of medication(s)**.

**TO PHYSICIAN:**

This patient has requested Student Health Services give them allergen immunotherapy ordered by you. We are pleased to do this in the capacity of an agent for you. We require you to supply the medication(s) and we supply disposable syringes and needles. **Allergy extracts must be properly labeled with patient name, date of birth, antigen content, concentration, and the expiration date. The Registered Nurse must use the date written on the vial as the** **actual expiration date**. **The Nurse cannot take verbal orders to** **extend the expiration date**. The medications are given by a Registered Nurse and there is a medical provider available when there are any untoward reactions requiring immediate medical care.

Any decision regarding dose intervals, quantity, and changes in dosing due if patient is late for an injection or due to reactions to the drug must come from you. Therefore, we need precise information from you, and we request that you complete the following data sheet. Please note that “See Attached” is not acceptable. If problems develop that are not answered by the information you give us, we will contact you for further instructions.

In setting up your orders for Student Health Services, please keep in mind times such as semester and summer breaks when your patient will not be at Elon University and instruct them and us accordingly. We cannot begin giving immunotherapy without receiving the enclosed form completed and signed by you. We will give the patient a copy of their immunotherapy record when they return to your care. **Procedures that are not performed at Student Health Services are addition of epinephrine or normal saline to injections. If either of these is necessary in the administration of allergy injections for the student, they will need to locate a medical provider who can provide** **these services**.

We look forward to assisting you in caring for your patient.

Ginette Archinal, MD

University Physician and Medical Director

Elon University

**REQUEST FOR ALLERGY IMMUNOTHERAPY ORDERED BY NON-STUDENT HEALTH SERVICES PHYSICIAN**

**PLEASE PRINT**

**Patient’s Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE**: **This form must be completed in detail before allergen extracts will be administered at Student Health Services. Please do not write “See Enclosed Instructions.”**

To better serve your patient, we are requesting the following information be completed. Please note that reference to “see attached documentation” will not be accepted.

Patient needs to have a current **non expired** epi-pen. Epi-pen must be brought to each appointment/day of injection.

Patient **must** take their antihistamine daily and the day of their appointment/day of injection.

**1. Last allergy injection**: Date\_\_\_\_\_\_\_\_\_\_ Dose\_\_\_\_\_\_\_\_\_ Strength\_\_\_\_\_\_\_\_\_\_\_\_

2. **Is your patient prescribed a daily Antihistamine or other Pre-medication prior to their allergy injection?**

Yes **\_\_\_\_\_** Name of Drug\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How soon prior to injection \_\_\_\_\_\_\_\_\_\_\_

No **\_\_\_\_\_**

3. **Is your patient in the Buildup phase currently**?

Yes \_\_\_\_\_

No\_\_\_\_\_\_

If yes, what dose are that currently at \_\_\_\_\_\_\_\_\_\_ mL.

What vial of concentration are they on for buildup \_\_\_\_\_\_\_\_\_ and color of vial top \_\_\_\_\_\_\_

increase each dose by\_\_\_\_\_ mL, every \_\_\_\_\_\_ to \_\_\_\_\_\_days (minimum to maximum)

until maximum dose of \_\_\_\_\_\_mL.

Frequency of buildup phase \_\_\_\_\_\_\_\_\_\_ weekly, weeks **(circle one)**

**PROCEED:**

to next concentration vial \_\_\_\_\_\_\_ and color of vial top \_\_\_\_\_\_\_\_

What is the start dose for new vial \_\_\_\_\_\_\_mL?

increasing each dose by \_\_\_\_\_ ml every \_\_\_\_\_ to

\_\_\_\_\_\_ days (minimum to maximum) until maximum dose of \_\_\_\_\_ml.

4. **Is your patient in the** **Maintenance Phase currently?**

Yes \_\_\_\_\_\_

No \_\_\_\_\_\_

If yes, what dose are they currently at \_\_\_\_\_\_\_\_\_mL**.**

increase each dose by \_\_\_\_\_\_\_\_ mL, every **\_**\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_ days (minimum to maximum) until maximum dose met \_\_\_\_\_\_\_ mL.

Once maximum dose is obtained, what frequency \_\_\_\_\_\_\_\_\_\_\_\_.

5. **New maintenance Vials**

What is the start dose \_\_\_\_\_ mL.

Buildup dose by \_\_\_\_\_\_ mL.

Frequency \_\_\_\_\_\_\_\_.

Maximum dose \_\_\_\_\_\_\_\_ mL.

Frequency once maximum dose met \_\_\_\_\_\_\_\_\_\_.

6. **Previous reactions (requiring dosage adjustment)**?

 Yes \_\_\_\_\_\_

 No \_\_\_\_\_\_

If yes, please explain.

7. **REQUIRED** **waiting time is 20 minutes** after immunotherapy (allergy injection (s))unless youspecify another interval of time. \_\_\_\_\_\_ minutes

8. Instructions for adjustment of dosage following a **local reaction**:

|  |  |
| --- | --- |
| Redness: | Recommended Adjustment: **Please Specify** |
|  Pea-sized (8mm) |  |
|  Dime –sized (18mm) |  |
|  Nickel-sized (20mm) |  |
|  Quarter-sized (24mm) |  |
|  30mm |  |
|  40mm |  |
| Induration/swelling: |  |
|  Pea-sized (8mm) |  |
|  Dime-sized (18mm) |  |
|  Nickel-sized (20mm) |  |
|  Quarter-sized (24mm) |  |
|  30mm |  |
|  40mm |  |
| Other: |  |
|  |  |

**Late shots:** We recognize that sometimes students are unable to keep the recommended shot schedule due to illness, breaks, travel, negligence, or other circumstances. We will not give shots if the student is wheezing or has lower respiratory infection or if they are febrile. To expedite your patient’s care would you please give us instructions for this situation?

9**. CHOOSE AND COMPLETE** *WHAT APPLIES TO YOUR PROTOCOLS*

|  |  |  |
| --- | --- | --- |
| Dose Change | Minimum number of days since last shot | Maximum number of days since last shot |
| Continue increasing if below maintenance dose |  |  |
| Repeat dose |  |  |
| Decrease dose by .05 |  |  |
| Decrease dose by .1 |  |  |
| Decrease dose by .2 |  |  |
| Decrease dose by .3 |  |  |
| Decrease dose by .4 |  |  |
| Call home allergist for dose |  |  |

**Elon University does not do vial testing**.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

 *Physician’s signature (mandatory) Date*

*\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 *Physician’s name- please print*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 *Office Address Office Number*

 *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 Fax Number

Please return this form to:

R. N. Ellington Center for Health and Wellness

Student Health Services

Campus Box 2040

Elon University

Elon, North Carolina 27244

Phone: 336-278-7321

Fax: **336-538-6506**