HEALTHEU
FOR YOU · FOR US · FOR OUR COMMUNITY

Elon University
Campus Box 2040
301 South O'Kelly Avenue
Elon, NC 27244
Phone: 336-832-7230
Fax: 336-538-6506

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 Provider must use the date written on the vial as the actual expiration date**. **The Provider cannot take verbal orders to extend the expiration date**. The medications are given by the Clinical Medical Staff 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.

Dr. Terry Thao Le, ABFM
University Physician and Medical Director
Elon University

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PLEASE PRINT

Patient's Name_____ **DOB**_____ **Date** _____

NOTE: This form must be completed in detail by a *PHYSICIAN/CLINICAL MEDICAL STAFF* 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 _____

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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 you specify 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: 336-278-7230
Fax: 336-538-6506