Allergen Immunotherapy Prescribing Physician Form

For your patient's safety and to facilitate the transfer of all allergy treatment to our clinic, this form must be completed to provide standardization and prevent errors. Failure to complete this form will delay or prevent the patient from utilizing our services. Form can be delivered by patient, mailed, or faxed to (833) 642-0486

Patient Name:_____ Date of Birth:_____

Provider:_____ Clinic Name:_____

Phone:_____ Office Address:_____

Fax:_____

Email:_____

Pre-Injection Checklist:

1. Does Patient have a history of asthma? YES or NO
2. Has patient had systemic reaction in past? YES or NO
3. Is patient required to take an antihistamine prior to injection? YES or NO
4. Is patient required to carry an Epinephrine Auto-Injector to receive allergy injections? YES or NO
5. Are peak flows required for each visit? YES or NO or OTHER:_____
   - If yes, please include parameters: _____
7. Is patient able to receive an influenza vaccine on the same day as allergy injection? YES or NO___
8. Date of last allergy injection:_____
9. Maintenance therapy GOAL: Concentration:_____ Dose:_____ Interval:_____
   - If yes, please provide grace period:_____

Please provide the following required information:

Patient's building/dosage schedule
Documentation of previous injections received (flow sheet)
New vial order form and instructions
Copy of patient's list of antigens in each vial mix
Protocol for localized reactions

Management of Missed Injections:

During build up phase	*After reaching maintenance*
_____to_____days: continue as scheduled	_____to_____days: give same maintenance dose
_____to_____days: repeat previous dose	_____to_____days: reduce previous dose by
_____to_____days: reduce previous dose by____	_____to_____days: reduce previous dose by____
_____to_____days: reduce previous dose by____	Over_____days – contact office for instructions
Over_____days – contact office for instructions	
Other Instructions:	

Acknowledgements:

___I have reviewed the Management of Systemic Reactions Protocol and agree with the use of this protocol for my patient if systemic reaction occurs.

___I understand that University Health Services does not give the initial dose of allergen immunotherapy.

Provider Signature:_____ **Date:**_____

Patient Name: UIN:

University Health Services Preventive Medicine
Management of Systemic Reaction in Outpatient Setting Protocol

If signs of allergic reaction or anaphylaxis (Airway obstruction, Bronchospasm, or Hypotension) are recognized the following algorithm will be initiated:

1. Removal of allergen (if still present)
2. INTRAMUSCUALR EPHINEPHRINE will be administered immediately without delay. Epinephrine will be administered into mid-lateral thigh if possible. Otherwise, largest accessible muscle will be utilized.
    - Epinephrine 1:1000 (1mg/ml) IM 0.3mg will be administered every 5-10 minutes. Up to 3 doses until response is achieved.
    - If no response is achieved, patient will be transported to local Emergency Department via EMS.
3. Supportive Care management:
    - Antihistamine administration:
        - Xyzal (Levocetirizine) 5mg will be administered if patient is able to swallow.
        - Diphenhydramine 25-50mg IM will be administered if patient is unable to swallow.
    - Hypotensive:
        - Intranasal high flow oxygen will be administered and airway support if necessary.
        - Intravenous normal saline fluids (20mg/kg rapidly) will be given through 2 large bore IVs.
    - Evidence of Bronchospasm:
        - Albuterol 0.083mcg nebulizer treatment will be given.
    - Observation: patient will be observed at Student Health Services for 1 hour after symptoms have resolved to monitor for prolonged and biphasic reactions.
4. Follow up Treatment
    - Corticosteroids:
        - Oral vs IM steroids will be considered to suppress biphasic reaction.
    - Adrenaline auto injector:
        - Auto injector will be prescribed if patient does not already have prescription.
    - Allergist follow up:
        - Encounter visit will be faxed to allergist for follow up plan and adjustments.

Prescribing Physician's Signature (REQUIRED) **DATE**