



Patient Name: \_\_\_\_\_  
UIN: \_\_\_\_\_

## 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.

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

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Physician: \_\_\_\_\_ Office Address: \_\_\_\_\_  
Office Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Pre-Injection Checklist:**

1. Is peak flow required prior to injection? \_\_\_\_Y \_\_\_\_N  
 *If Y, please include parameters.*
2. Is student required to take an antihistamine prior to injection? \_\_\_\_Y \_\_\_\_N
3. Is the student required to keep Epinephrine Auto-Injector in close proximity to have injection? \_\_\_\_Y \_\_\_\_N
4. Date of Last Injection: \_\_\_\_\_  
- **NOTICE: Student Health Services does not give the initial dose of allergen immunotherapy.**
5.  Please include build schedule
6.  Please provide parameters for management of local reactions

**Management of Missed Injections (According to number of days from Last Injection):**

During build up phase:

- \_\_\_\_ to \_\_\_\_ days – continue as scheduled
- \_\_\_\_ to \_\_\_\_ days – repeat previous dose
- \_\_\_\_ to \_\_\_\_ days – reduce previous dose by \_\_\_\_ ml
- \_\_\_\_ to \_\_\_\_ days – reduce previous dose by \_\_\_\_ ml
- Over \_\_\_\_ days – contact office for instructions.

After Reaching Maintenance:

- \_\_\_\_ to \_\_\_\_ days – give same maintenance dose
- \_\_\_\_ to \_\_\_\_ weeks – reduce previous dose by \_\_\_\_ ml
- \_\_\_\_ to \_\_\_\_ weeks – reduce previous dose by \_\_\_\_ ml
- Over \_\_\_\_ weeks – contact office for instructions

Other instructions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## SHS 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. INTRAMUSCULAR EPINEPHRINE 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 (1 mg/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:
    - i. Xyzal (Levocetirizine) 5mg will be administered if patient is able to swallow.
    - ii. Diphenhydramine 25-50mg IM will be administered if patient is unable to swallow.
  - Hypotensive:
    - i. Intranasal high flow oxygen will be administered and airway support if necessary.
    - ii. Intravenous normal saline fluids (20mg/kg rapidly) will be given through 2 large bore IVs.
  - Evidence of Bronchospasm:
    - i. 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:
    - i. Oral vs IM steroids will be considered to suppress biphasic reaction.
  - Adrenaline auto injector:
    - i. Auto injector will be prescribed if patient does not already have prescription.
  - Allergist follow up:
    - i. Encounter visit will be faxed to allergist for follow up plan and adjustments.

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

**DATE**