Campus Health Services at the University of North Carolina at Chapel Hill
CB #7470 | (p) 919.966.2281 | (f) 919.966.0616 | campushealth.unc.edu

TO PATIENT

Campus Health Services (CHS) can give you allergy injections while you are a student at UNC. In order to safely and effectively care for you, we must have detailed information from your physician covering all circumstances that may occur during the course of your therapy. Injections will not be given if instructions are inadequate. Your allergist will continue to manage your care, and CHS will serve as a temporary extension of your allergist's office. You and your physician will be responsible for providing the allergy serum, and CHS administers your injections. We cannot be held responsible for loss or breakage of vials occurring outside of Campus Health, and we do not ship serum. Thank you for your cooperation and we look forward to working with you.

TO PHYSICIAN

Your patient has requested that Campus Health Services (CHS) administer his/her Allergy Immunotherapy while a student at UNC. We require that you complete the following data sheet. This will serve as your orders for dose adjustments regarding reactions or non-compliance. If problems develop that are outside of the parameters you provide, we will contact you for direction. We cannot begin therapy until completed and signed orders are received. Any sections that are not addressed will be sent back to you for completion. These orders will need to updated on an annual basis.

We require you to supply the patient's serum. We will provide the needles, syringes, and emergency medications in our role as an agent for you. Allergy extracts must be properly labeled with the patient's name, date of birth, vial contents, concentration, and expiration date. There must be a matching shot record for each vial sent. Campus Health does not perform vial testing, serum dilution, or the addition of epinephrine to the serum.

Therapy is administered by a Registered Nurse and is only given when a physician is available on the premises for emergency situations. We have a complete protocol for anaphylaxis with all needed emergency equipment and medications available. Should a systemic reaction occur you will be provided with a complete report and consulted for dose adjustments prior to the patient's next visit.

When a patient returns to your office to receive injections during breaks or office visits, his/her serum and shot record will be packaged to take along. Please note that any shot records you receive will be printed from the patient's electronic health record at CHS. When the patient returns to us, we request a copy of all documented injections given in your office so that we can provide uninterrupted therapy to the patient.

Thank you for your assistance in providing a safe and effective allergy immunotherapy experience for our mutual patient. Please feel free to contact the Campus Health Allergy Clinic (919) 966-6664 with any questions or concerns you may have. We look forward to working with you and your patient.

Campus Health Services

REQUEST FOR PARENTERAL (INJECTION) THERAPY ORDERED BY NON-CAMPUS HEALTH SERVICES PHYSICIANS

PLEASE PRINT

________________________________ ______________ ____________

Patient's Name Date of Birth Date

____

Patient Identification Number

NOTE: IN ORDER TO SAFELY SERVE YOUR PATIENT, THIS FORM MUST BE COMPLETED IN DETAIL BEFORE ALLERGEN EXTRACTS WILL BE ADMINISTERED AT CAMPUS HEALTH SERVICES.

1. **Special instructions** (premedication, peak flow, etc.):

2. **Build Up Schedule** (Since Last Injections):

Increase by _____ml every _____to _____ days

From _____to _____ days repeat dose

From _____to ______days drop by _____ml

From _____to ______days drop by _____ ml

From _____to ______days drop by _____ ml

Over _____days call office for instructions

3. **Maintenance dose** is, or will be _____ ml every _____ to _____ days of Vial _____ (concentration)

4**.** Late Schedule for ***Full Maintenance Dose*** (Since Last Injections:)

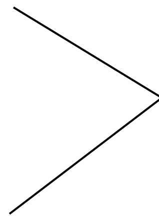
Up to _____ days, no change

From _____to _____ days drop by _____ ml

From _____to _____ days drop by _____ ml

From _____to _____ days drop by _____ ml

Over _____days call office for instructions



Then rebuild by _____mL

Every ______ to ____ days

5. **New Maintenance Vial**:

Drop by _____ml for first dose.

Build by _____ml every _____to _____ days

From _____to _____ days repeat dose

From _____to ______days drop by _____ml

From _____to ______days drop by _____ ml

From _____to ______days drop by _____ ml

Over _____days call office for instructions

6. **Dose adjustments for local reactions** are based on _____redness _____wheal _____soft tissue swelling. (Please specify this.)

From _____to _____ increase dose as scheduled

From _____to _____ mm repeat dose

From _____to _____ mm drop by _____

From _____to _____ mm drop by _____

From _____to _____ mm drop by _____

Over _____mm call office for instructions.

Maintenance patients: rebuild by _____mL every ____ to ____ days until patient is back at maintenance after decreasing dose due to local reactions.

7. Please indicate below any **conditions/illnesses/ increased allergy symptoms for which you would like dose adjustments** to be made.

8. **Use of antibiotics**:

____may give allergy injections

____withhold allergy injections

9. Has the patient experienced any significant local or systemic reactions to allergy immunotherapy in the past? If so, please describe symptoms, extract responsible, if known, and treatment that was required.

10. **Wait time** (CHS policy is at least 20 minutes and is strictly enforced.):

____ 20 minutes

____ 30 minutes

________________________________	________________________________
Physician Signature	Street Address
________________________________	________________________________
Physician's Name, printed	City, State, Zip Code
________________________________	________________________________
Telephone Number	Fax Number