



University of North Carolina at Chapel Hill
Campus Health, CB# 7470
Chapel Hill, NC 27599-7470
Telephone 919/966-2281/Fax 919/966-0616

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

TO PATIENT:

Campus Health desires to assist you in receiving allergy immunotherapy ordered by a non-Campus Health physician while you are a patient here. We do this by serving temporarily as the agent of that physician. He/she remains, in effect, your physician in relation to the condition for which you are being treated. Therefore, 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 or loss of medication(s).*

TO PHYSICIAN:

This patient has requested Campus Health give him/her 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 physician 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 Campus Health, please keep in mind times such as semester and summer breaks when your patient will not be at the University of North Carolina at Chapel Hill and instruct him/her and us accordingly. We require written orders when we administer medication from a physician located elsewhere. We cannot begin giving immunotherapy without receiving the enclosed form, both completed and signed by you. We, in turn, will give the patient a copy of his/her immunotherapy record, if requested, when he/she returns to your care. ***Procedures that are not performed at Campus Health are addition of epinephrine or normal saline to injections. If either of these is necessary in the administration of allergy injections for the student, he/she will need to locate a medical provider who can provide these services.***

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

Thevy Chai, MD
Director of Medical Services



University of North Carolina at Chapel Hill
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ORDERED BY NON-CAMPUS HEALTH SERVICES PHYSICIAN

PLEASE PRINT

Patient's Name Date of Birth Date

NOTE: This form must be completed in detail before allergen extracts will be administered at Campus Health. Please do not write "See Enclosed Instructions."

In order 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 carry epi-pen day of injection
___ does not need to carry epi-pen

Patient ___ needs peak flow prior to injection
___ does not need peak flow
___ hold if peak flow < ___

Patient ___ needs to premedicate with ___
___ does not need to premedicate

Parental Injections

Build-Up

During build-up, ___ See Shot Record
Late schedule doses decreased by ___ mL

Build-up dosing:

Must have ___ days between injections
May increase dosage up to ___ days since last injection
___ to ___ days since last injection = REPEAT DOSE
___ to ___ days since last injection = drop back 1 dose
___ to ___ days since last injection = drop back 2 doses
over ___ days = call allergist office

Maintenance

Maintenance dose is ___ mL every ___ days or ___ weeks of ___ concentration/Vial # and at least ___ days between doses.

New maintenance vial: drop back ___ doses from previous vial
Increase by ___ mL every ___ days
No more than ___ days between an increased dose

Late schedule for maintenance dosing: must be at least ____ days or ____ weeks since last injection

Days since last injection:

Up to ____ days, no change

Day ____ through day ____, drop back ____ dose(s) or ____ mLs

Day ____ through day ____, drop back ____ dose(s) or ____ mLs

Day ____ through day ____, drop back ____ dose(s) or ____ mLs

Over ____ days call office

Product Name and dosing if receiving Sublingual Immunotherapy:

-
1. Please define grades of local reactions in term of redness and/or swelling/wheal and any dose adjustments

2. Specific guidelines for dosage adjustment:

Illness: _____(specify illness)

____withhold

____decrease dose by ____mL

Wheezing:

____withhold

____decrease dose by ____mL

Increased allergy symptoms:

____withhold

____decrease dose by ____mL

Use of antibiotics:

____withhold

____may receive allergy injection(s)

3. Has the patient experienced previous significant local or systemic reactions to allergy extracts?

[] YES [] NO

If YES, indicate type of reaction, what extract(s) and previous treatment for adverse reaction:

4. Is patient taking any Beta-Blockers? [] YES [] NO

Is the Beta-Blocker taken PRN [] YES [] NO

Allergy injections will not be administered by Campus Health if the patient has taken a Beta Blocker (such as Propanolol) in the 24 hours prior to their allergy injection.

4. Is vial testing via the intradermal route when a new vial is started being ordered?

YES NO

If YES, indicate amount of serum to be administered intradermally : _____ml

If Yes, indicate wheal measurement that is safe to proceed with subcutaneous injection at next visit:

_____mm

If Yes, indicate wheal measurement in which the new vial should be held and patient should contact allergist for adjustment to concentration of allergy serum (**note that Campus Health does not return ship serum. If the vial test is not passed and dilution is needed, the patient is responsible for returning serum to the allergist**):

_____mm

Additional instruction:

NOTE: A ____20____30 minute waiting time after immunotherapy administration) will be enforced per Campus Health policy.

Physician's Signature

Street Address

Physician's Name (please print)

City State Zip Code

(_____)_____
Fax Number

(_____)_____
Telephone Number