MM-19 Attachment 1

University of North Carolina at Chapel Hill
Campus Health Allergy Clinic
James A. Taylor Building CB# 7470
320 Emergency Room Drive Chapel Hill, NC 27599-7470
Telephone 919-966-2281 Fax 919-966-0616

REQUEST FOR ALLERGEN IMMUNOTHERAPY ADMINISTRATION

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. They remain, 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 administer 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 or Medical Assistant (RN or MA) must use the date written on the vial as the actual expiration date. The RN or MA cannot take verbal orders to extend the expiration date.** The medications are given by an RN or MA 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 the 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 them and us accordingly. We require written orders annually 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 their immunotherapy record, if requested, when they return 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, they will need to locate a medical provider who can provide these services.***

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

Daniel Jobe, MD
Director of Medical Services

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Campus Health Services, CB# 7470
Chapel Hill, NC 27599-7470
Telephone 919-966-2281 Fax 919-966-0616

REQUEST FOR ALLERGEN IMMUNOTHERAPY ADMINISTRATION

PLEASE PRINT

_____ _____ _____
Patient's Name Date of Birth Today's 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."

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
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:

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

1. Please define size of local reactions in terms of redness and/or swelling and/or wheal and any ordered dose adjustments based on defined reaction grades.

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 propranolol) 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 wheal measurement exceeds what is deemed safe, 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**):

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

UNC Campus Health: 09/09
Revised: 3/11, 6/17
Reviewed: 4/14, 6/19, 6/22, 8/22, 7/24, 6/25