

## Allergen Immunotherapy Order Form

\*\*MUST BE FILLED OUT IN ITS ENTIREITY FOR YOUR PATIENT TO RECEIVE INJECTIONS\*\*

| Patien                          | nt Informati                    | ion                               |                         |                          |  |                         |                   |      |
|---------------------------------|---------------------------------|-----------------------------------|-------------------------|--------------------------|--|-------------------------|-------------------|------|
| Patient                         | t Name:                         |                                   |                         | DOB:                     |  |                         |                   |      |
| Allergis                        | st Name:                        |                                   |                         |                          |  |                         |                   |      |
|                                 |                                 |                                   |                         |                          |  |                         |                   |      |
| Facility                        |                                 |                                   |                         |                          |  |                         |                   |      |
| Facility Address: Phone Number: |                                 |                                   |                         | _                        | Number:                                      |                         |                   |      |
|                                 | Number for La                   |                                   | 01                      |                          |  |                         |                   |      |
|                                 |                                 |                                   | -                       |                          |  |                         |                   |      |
| Phone                           | Number and F                    | Fax Number fo                     | r Mixing Office         | e (if different fr       | om above):                                   |                         |                   |      |
|                                 |                                 |                                   |                         |                          |  |                         |                   |      |
| Injecti<br>** Date<br>Begin w   | ion Schedue of Last Injectivith | Ile/Buildup ion (s):(dilution) at | Scheduleml (doscan be a | vial(s) se) and increase | and Dose(s) gose according to repeat every _ | give:<br>o the schedule | by unt            | il a |
| Б                               | ilution                         | <u> </u>                          |                         |                          |  | ·<br>                   |                   |      |
|                                 | ial/Cap Color                   |                                   |                         |                          |  |                         |                   |      |
|                                 | xpiration Date                  | /                                 | /                       | //                       | /  | /                       | //                |      |
|                                 |                                 | ml                                | ml                      | ml                       | ml   | ml                      | ml                |      |
|                                 |                                 | ml                                | ml                      | ml                       | ml   | ml                      | ml                |      |
|                                 |                                 | ml<br>ml                          | ml<br>ml                | ml<br>ml                 | ml<br>ml                                     | ml<br>ml                | ml<br>ml          |      |
|                                 |                                 | ml                                | ml                      | ml                       | ml   | ml                      | ml                |      |
|                                 |                                 | ml                                | ml                      | ml                       | ml   | ml                      | ml                |      |
|                                 |                                 | ml                                | ml                      | ml                       | ml   | ml                      | ml                |      |
|                                 |                                 | ml<br>Next dilution               | ml<br>Next dilution     | ml<br>Next dilution      | ml<br>Next dilution                          | ml<br>Next dilution     | ml<br>maintenance |      |
|                                 |                                 | ivext dilution                    | ivext dilution          | ivext dilution           | ivext dilution                               | INEXT UIIULIOII         | mannenance        |      |



## Management of Missed Injection: (According to the # of days since last injection)

| During Build-Up Phase  | After Reaching Maintenance                       |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| to days continue as scheduled  | todays maintain maintenance dose                 |  |  |  |  |  |  |
| to days repeat previous dose   | todays reduce previous dose byml                 |  |  |  |  |  |  |
| to days reduce previous dose byml  | to days reduce previous dose byml                |  |  |  |  |  |  |
| todays reduce previous dose byml   | Overdays contact office for written instructions |  |  |  |  |  |  |
| Overdays contact office for written instructions   |  |  |  |  |  |  |  |
| Repeat dose if swelling is >mm and <  Reduce by one dose if swelling is >mm  Rebuilding after missed injections or reactions |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| *Pt is to return everydays, increasing byml until  |  |  |  |  |  |  |  |
| Extracts should be shipped:  |  |  |  |  |  |  |  |
| (All extract is shipped Mon-Tues-Wed from PUSH as Next Day delivery with tracking number available)                          |  |  |  |  |  |  |  |
| ☐ No ice ☐ On ice  |  |  |  |  |  |  |  |
| Provider Signature:  PUSH will accept the following legal signatures Hand-signed (wet signature)                             | Date:  |  |  |  |  |  |  |

Order is valid for one year

Provider's unique signature stamp

Time stamped and validated electronic signature