Form 2

PURDUE CENTER FOR HEALTHY LIVING
ADMINISTRATION OF ALLERGEN IMMUNOTHERAPY FORM

Physician's Practice: Please print or type the following information and submit via fax to 765-496-6656 or mail to 1400 W. State Street, Bldg. B, Suite C, West Lafayette, IN 47907. All information is required. The CHL is managed by One to One Health, LLC.

Patient name: _____ DOB: _____

Diagnosis: _____ **ICD-10 Code(s): _____

History (including previous reaction(s): _____

_____

Date and Amount of last Injection(s): _____

Vial Name: _____

Dilution: _____ Expiration date of Vial(s) _____

Interval between Injections: _____

Recommended Dosage: _____

Dosage Reduction for New Vials: _____

Dosage Reduction for Lateness: _____

Physician's Name (please print): _____

Board Certified Allergist: _____Yes _____No Licensed in STATE: _____Yes _____No

Address: _____ Phone: _____

Physician's Signature: _____ Date: _____

**Provision of this code will assist your patient in receiving medical insurance benefits.

Purdue Center for Healthy Living
1400 West State St., Bldg. B, Suite C
West Lafayette, IN 47907
P: 765-494-0111 | F: 765-496-6656
www.purdue.edu/hr/CHL

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