

**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.	