ALLERGY IMMUNOTHERAPY ORDER FORM

Purdue University Student Health Services
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Purdue University Student Health Services (PUSH) administers allergy immunotherapy for patients receiving ongoing care from allergy practices throughout the United States. Because treatment schedules and dosing protocols vary between practices, please provide complete dosing and administration instructions to support continuity of care.

ATTACHMENTS REQUESTED

Please attach the patient's current dosing schedule if the patient is in build-up, rebuild, new vial advancement, or any protocol where dose reductions may be required. Please ensure attached schedules are current and consistent with the instructions provided on this form.

Please provide the specific office location where the patient receives allergy injections and where serum should be shipped. Serum will be shipped to the address listed on this form.

PATIENT INFORMATION

Patient Name: _____ DOB: _____

ALLERGY OFFICE INFORMATION

Allergist: _____

Practice Name: _____

OFFICE WHERE THE PATIENT RECEIVES ALLERGY INJECTIONS

Office Name: _____

Street Address: _____

City: _____ Zip Code: _____ State: _____

Phone: _____ Fax: _____

Hours of Operation: _____

If applicable, Mixing Lab phone: _____ Fax: _____

PRE-INJECTION ORDERS

(If not checked, it will not be expected for patient to have completed prior to injection at PUSH.)

☐ Peak Flow Must be > _____ L/min to give injection. (Pt to bring with them to appointment).

☐ Antihistamine prior to injection (to be taken by patient prior to arriving at PUSH).

CURRENT IMMUNOTHERAPY STATUS

Date of Last Injection: _____ Current Vial/Concentration: _____

Current Dose: _____

The patient is currently in: ☐ Build-Up ☐ Maintenance

ATTACHMENTS INCLUDED

☐ Current dosing schedule ☐ Rebuild Schedule
☐ New vial schedule ☐ Reaction protocol

PURDUE UNIVERSITY | Student Health Services

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☐ Other: _____

INJECTION INTERVAL

Build-Up: _____ to _____ days

Maintenance: _____ to _____ weeks

Late Calculated From: ☐ Last injection date ☐ Scheduled due date

NEW VIAL INSTRUCTIONS (IF APPLICABLE)

☐ Follow rebuild instructions ☐ Restart advancement schedule

☐ Contact office ☐ No special instructions

☐ Other: _____

REBUILD INSTRUCTIONS

☐ Follow attached schedule ☐ Restart advancement schedule

☐ Contact office ☐ Other: _____

LOCAL REACTION / DOSE REDUCTION INSTRUCTIONS

If local reaction is ≥: _____ mm: _____

If local reaction is ≥: _____ mm: _____

If local reaction is ≥: _____ mm: _____

Systemic Reaction: _____

Rebuild after dose reduction:

☐ Follow attached schedule ☐ Increase _____ mL every _____ days/week

☐ Contact office ☐ Other: _____

When should serum be reordered? _____ Does the patient need to contact you? ☐ Y ☐ N

Extracts should be shipped:

(All extracts are shipped Mon-Tues-Weds from PUSH as Next Day delivery with tracking number available)

☐ No Ice ☐ On Ice

Physician Signature: _____ Date: _____