UNIVERSITY OF DELAWARE

Student Health Service

282 The Green
Laurel Hall
Newark, DE 19716-8101
Phone: 302-831-2226
Fax: 302-831-6407

Dear Allergist,

Student Health Services at the University of Delaware is committed to providing care for our students in the safest and most efficient way possible. Your assistance in ensuring a smooth transition process is greatly appreciated.

The University has seen an increase in students requesting continuation of allergy injections each year and each request comes with its own unique set of forms and instructions. To increase safety and decrease the risk of errors for our students, we have created a standardized Allergen Immunotherapy Order Form that we utilize for every patient seen in our Allergy clinic.

In order to administer allergy injections to your patient, we require the following:

- **Vials labeled with the following**:
    - Patient's name
    - Name of antigen(s) or vial identifier (with corresponding key)
    - Dilution
    - Expiration date
- The completed "**Allergen Immunotherapy Order Form**" on the following pages

Failure to provide this information can delay or prohibit your patient from continuing their allergy injections at the University of Delaware. Serum may be dropped off in person or mailed to the following address, Monday through Friday, 9:00am to 4:00pm. *Paperwork and forms may accompany the vials or be faxed to 302-831-8790.*

University of Delaware Student Health Services
282 The Green
Newark, DE 19716

University of Delaware Student Health Services also provides Primary Care, Gynecologic, Immunization, Nutrition, Lab, X-ray, and medical dispensary services. Please fax any necessary lab orders for your patient to us at 302-831-64-07

Please let us know if you have any questions or concerns about the process outlined above.

Thank you,

Jodie Scott, BSN, RN
Immunization Nurse Coordinator

Kelly M. Frick, MD
Interim Medical Director

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Allergy Immunotherapy Order Form

In order to provide safe and effective allergy injections to your patient, please complete the form in its entirety. "See attached" is not sufficient, and we will not be able to provide allergy injections until we receive this information.

Please fax the completed form to **302-831-8790** or mail to **UD Student Health Services, Attn: Immunization, 282 The Green Newark, DE 19716**. The patient may also hand deliver this form with their vials.

Patient Name: ______________________________ **Date of Birth:** ________________

To be completed by the allergist's office.

Allergist Name: ______________________________

Office Address: ______________________________

Phone #: ______________________________ **Fax #:** ________________

Does this patient have a history of?

☐Asthma ☐Systemic/Anaphylactic Reaction ☐Previous administration of epinephrine

Additional Details: ______________________________

____

Pre-Injection Checklist

Peak Flow?	☐No ☐Yes > _________L/min
Antihistamine?	☐No ☐Yes – When? __________________________
EpiPen/AuviQ	☐Yes - *An epinephrine auto-injector is required for all students receiving allergy injections at Student Health Services.*

Comfort Measures

Cold Spray	☐Yes
Hydrocortisone Cream	☐Yes
Antihistamine	☐Yes, if not already taken

Additional Pre-Injection or Comfort Measure instructions or orders:

____

____

Vial/Serum Information – "See attached" <u>is acceptable</u> for vial identification

Vial Identifier	Contents/Allergens

Schedule – “See attached” is NOT acceptable for schedule information

If additional spaces are needed or alternative regimens are used, please cross out this section and complete the extended schedule on page 4.

Vial #/Cap Color					
Dilution					
Expiration Date:	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	Go to next dilution	Go to next dilution	Go to next dilution	Go to next dilution	Maintenance

Injection Interval - *DAYS FROM LAST INJECTION* – “See attached” ***is NOT acceptable*** for interval instructions.

Build-up	**Maintenance***
_____ to _____ days Continue as scheduled	______ to ______ days Continue maintenance
_____ to _____ days Repeat previous dose	______ to ______ days *Reduce dose by _____ steps
_____ to _____ days Reduce previous dose by _____ steps	______ to ______ days *Reduce dose by _____ steps
_____ to _____ days Reduce previous dose by _____ steps	Over _______ days Contact office for instructions
	*☐Rebuild based on maintenance schedule interval
Over _______ days Contact office for instructions	*☐Rebuild based on build-up schedule interval

Local Reactions – Please provide additional instructions as needed.

If wheal is **>** _______ mm **and <** _______ mm **and** lasts longer than _______ hours then **Repeat Dose**

If wheal is **>** _______ mm **and** lasts longer than _______ hours then **Reduce Dose** by _____ step(s)

Additional Injection Instructions:

____

____

____

____

Allergist Signature: ____ **Date:** _______________

Extended or Alternative Regimen Schedule (Optional)

Vial #/Cap Color							
Dilution							
Content							
Expiration Date:	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
	ml	ml	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml	ml	ml
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	ml	ml	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml	ml	ml