DAVIDSON COLLEGE

Physician Request/Order for Allergy Injection Therapy

Patient Name:_____

DOB: _____ Davidson Student ID #_____

Your patient has requested that the Center for Student Health & Well-Being administer allergy immunotherapy while they are enrolled at the college during the academic year. To maximize safety, we require the following information be completed and signed.

Please review and initial each statement in the box to the left:

	Allergy injections are administered by a nurse with a healthcare provider (MD and/or Nurse Practitioner) present in the health center to manage any severe reactions that may occur. Students will be asked to wait in the health center for a minimum of 30 minutes after injections to observe for any reaction.
	Students **must initiate allergy injections with their prescribing physician** before receiving injections at the Student Health Center.
	All allergy serum must be properly labeled with the patient's name, DOB, concentration and expiration date.
	No expired serum will be administered
	A written order must be received annually from the prescribing physician before we can administer allergy injections to your patient.
	If any problems arise that are not addressed with the physician orders, we will contact your office for further instructions
	We require a written order to be signed by the physician and faxed to us within 24 hours with any deviation from the original order
	The Student Health Center does not mail serum on behalf of the student. Nor do we accept serum to be sent directly to the health center. New serum will need to be sent directly to the student/your patient
	For systemic reactions, Epinephrine (1:1000) is given IM 0.3 IM, in anterolateral thigh, and if hives or itching of skin/mucosal membrane or runny nose are present, Diphenhydramine 50mg is given IM in the deltoid. The allergist's office will be notified of the event and request further instructions and orders.

Please answer the following questions:

Has the patient experienced significant local or systemic reactions to allergy injections? _____NO _____YES
If yes, please describe the reaction, and responding treatment._____
_____

Is the patient taking a Beta-blocker? _____NO _____ YES.
The Student Health Center does not administer allergy injections to patients taking Beta-blockers.

DATE of LAST INJECTION _____

To better serve your patient, we are requesting the following information be completed. Please note, reference to "See Attached Documentation" WILL NOT BE ACCEPTED.

Patient _____needs to carry an epi-pen day of injection
_____does not need to carry an epi-pen

Patient _____ needs peak flow prior to injection. If yes, peak flow must be > _____ L/min
_____ does not need peak flow

Patient _____ needs to pre-medicate with _____ prior to injections
_____ does not need to premedicate

Please complete the reverse side for order and signature

Patient Name:_____ **DOB** _____

Injection(s) Build up and maintenance schedule(s)

	Frequency of injections
BUILD UP:	Every _____ to _____ days

	Frequency of injections
MAINTENANCE:	Every _____days or _____weeks

MANAGEMENT OF MISSED INJECTIONS: (According to # of days from ***LAST*** injection)

During Build-Up Phase	***After Reaching Maintenance***
▪ ____to_____days – continue as scheduled	▪ ____to_____weeks – give same maintenance dose
▪ ____to_____days – repeat previous dose	▪ ____to_____weeks – reduce previous dose by_____(ml)
▪ ____to_____days – reduce previous dose by_____(ml)	▪ ____to_____weeks – reduce previous dose by_____ (ml)
▪ ____to_____days – reduce previous dose by_____(ml)	▪ Over_____weeks – contact office for instructions
▪ Over_____ days – contact office for instructions	

REACTIONS:

At next visit: Proceed with next dose if swelling is < _____mm

Repeat next dose if swelling is > _____mm and < _____mm

Reduce next dose by _____ml if swelling is > _____mm

Call the office if >_____mm or systemic reaction.

Other Instructions:

_____

_____

Physician Signature: _____ Date: _____

Physician Name (please print) _____

Office Address: _____

Office Phone: _____ Fax: _____

The Davidson Student Health Center nursing staff will call your office for any clarifications in orders prior to giving injections.