WAKE FOREST UNIVERSITY
Deacon Health

Dear Allergist office,

Wake Forest University Deacon Health looks forward to collaborating with you to continue allergy immunotherapy for your patient while they are enrolled at Wake Forest. To ensure safe and effective administration of allergy injections, please complete attached **PROVIDER ORDER FOR ALLERGY IMMUNOTHERAPY** form in its entirety. This form must be submitted **before** we can continue immunotherapy. Incomplete forms will be returned or clarified, which may delay or disrupt your patient's treatment.

Please review the following important requirements:

- Patient's initial injection(s) must be performed at an allergist's office.
- Each vial must be **clearly labeled** with **the patient's name, date of birth, dilution, expiration date, and specific allergen(s) contained within.**
- No expired serum will be administered. Exceptions must be explicitly noted on the order form (e.g. "Okay to use serum one month beyond expiration date.")
- **New serum vials must be sent directly to the patient,** not Deacon Health.
- In the event of a systemic reaction, epinephrine 0.3mg (1:1000) intramuscular (IM) will be administered.
- Patients must carry and present a non-expired epinephrine auto-injector to each appointment. **Students who do not have epinephrine in their possession at the time of the visit will not receive their injection.** Please ensure your patient has a current prescription.
- If symptoms such as hives, mucosal itching, or rhinorrhea develop after immunotherapy administration, diphenhydramine 50mg IM will be given, unless otherwise specified by your office on the **order form.**
- The allergist's office will be notified in the case of a systemic reaction. **No further immunotherapy injections will be given until the patient is reevaluated by the allergist and new orders are received and approved**.
- Allergy injections will not be administered if the patient is ill, febrile, wheezing, has an upper respiratory infection, or has hives or an undiagnosed rash.
- Allergy injections will only be administered when a medical provider is on site. While a physician is usually present, there may be times when only advanced practice providers are available.
- Please fax completed forms to Deacon Health at 336-758-6054.

Exclusion criteria

- Patients on a beta-blocker or monoamine oxidase inhibitor (MAOI).
- Patients receiving venom immunotherapy, including mixed vespid and whole body extracts.
- Deacon Health reserves the right to discontinue this service and refer back to you for management should any safety concerns develop while under care.

Sincerely,
Deacon Health

Provider Order for Allergy Immunotherapy

For your patient's safety and to facilitate the transfer of allergy treatment to our clinic, this form must be completed to provide standardization and prevent errors. Failure to complete this form may delay or prevent the patient from utilizing our services. This form can be delivered by the patient, mailed, or faxed (see address and fax below).

Patient Name: _____ Date of Birth: _____
Provider: _____ Practice Name: _____
Office Phone: _____ Fax: _____

Pre-Injection Checklist:

- Does your patient have a history of asthma? **YES** ❑ **NO** ❑
- History of anaphylaxis? **YES** ❑ **NO** ❑
- Do you require your patient to take an antihistamine prior to receiving allergy injections? **YES** ❑ **NO** ❑
- Do you require a peak flow prior to injections? **YES** ❑ **NO** ❑
    - If **YES**, peak flow must be >_____ L/min.
- Length of time the patient must remain in the clinic after injection: _____ minutes.

Allergy Vials:

Vial	**Vial Contents (Allergens)** ***Do not use abbreviations***	**Vial Dilution**	**Last Dose Given (mL)**	**Date of Last Dose**
Ex: Vial A	Cat, Dog, Grass	1:100	0.3	5/1/2022

Injection Schedule:

	Frequency of Injections
Build Up	Every _____ days.
Maintenance	Every _____ days or _____ weeks.

Management of Missed Injections: (according to time elapsed since ***LAST*** injection)

During Build-Up	**During Maintenance**
____ to ____ days – continue as scheduled	____ to ____ weeks: give same maintenance dose
____ to ____ days – repeat previous dose	____ to ____ weeks: reduce dose by _____
____ to ____ days – reduce previous dose by _____	____ to ____ weeks: reduce dose by _____
____ to ____ days – reduce previous dose by _____	____ to ____ weeks: reduce dose by _____
Over ____ days: contact office for instructions	Over ____ weeks: contact office for instructions

Dilution					
Vial Cap Color					
	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	**Maintenance**
	mL	mL	mL	mL	**Dose will be:**
	Next dilution	Next dilution	Next dilution	Next dilution	mL

Maintenance New Vial Instructions: _____

_____

Reactions:

At next visit:

Repeat previous dose if swelling is > _____mm.
Reduce previous dose by _____ if swelling is >_____ mm.
Reduce previous dose by _____ if swelling is >_____ mm.
Call the office if swelling >_____ mm or for systemic reaction.

Other Instructions:

_____

_____

Provider Signature: _____ Date: _____

Office Address: _____

Wake Forest University Deacon Health will call your office if clarifications are needed.