



Physician Request/Order for Allergy Injection Therapy

Patient Name: _____

DOB: _____ Lees-McRae Student ID #: _____

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

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

	Allergy injections are administered by a nurse or Nurse Practitioner. 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 physicians BEFORE receiving injections at the Student Health Clinic.
	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 scanned and emailed to the Student Health Clinic (healthservices@lmc.edu) within 24hrs with any deviation from the original order.
	The Student Health Clinic 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 ML in the 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?

____ Yes, ____ No

If yes, please describe the reaction, and responding treatment.

Is the patient taking a Beta-blocker? ____ Yes, ____ No

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 be premedicated with _____ prior to injections
_____ does not need to be premedicated

Please complete the next page 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
<ul style="list-style-type: none">• ___ to ___ days – continue as scheduled	<ul style="list-style-type: none">• ___ to ___ weeks – give same maintenance dose
<ul style="list-style-type: none">• ___ to ___ days – repeat previous dose	<ul style="list-style-type: none">• ___ to ___ weeks – reduce previous dose by ___(ml)
<ul style="list-style-type: none">• ___ to ___ days – reduce previous dose by ___(ml)	<ul style="list-style-type: none">• ___ to ___ weeks – reduce previous dose by ___(ml)
<ul style="list-style-type: none">• ___ to ___ days – reduce previous dose by ___(ml)	<ul style="list-style-type: none">• Over ___ weeks – contact office for instructions
<ul style="list-style-type: none">• 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: _____

Office email: _____

The Lees-McRae Student Health Clinic staff will call your office for any clarifications in orders prior to giving injections.

