Dear Allergy provider,

The W&M Student Health Center’s goal is to provide care needed by our students in the safest way possible. Your assistance with this goal is not only required, but also greatly appreciated.

Our staff provides allergy injections to students referred by numerous allergy specialists across the country, each with their own unique form. Without a consistent format, the possibility for omissions or errors may increase. Therefore, to maximize the safety margin for our students, our clinic has developed an allergy immunotherapy administration form that we will utilize for every student patient in our allergy clinic.

In order for students to receive allergy immunotherapy at the W&M Student Health Center, we require the following:

- Initial injections must be performed at the Allergist’s office
- If there has been a four month lapse in injections, student must return to Allergist office to resume injections before being able to continue immunotherapy at W&M
- We will not mix or dilute any extracts; this must be done by the prescribing office. We will store extracts at the SHC.
- Each vial must be labeled with:
  - Patient’s name
  - Date of birth
  - Content of vial(s)
  - Dilution/strength
  - Expiration date
- The Allergy Immunotherapy administration form must be completed prior to the patient receiving injections at the W&M SHC.

Vials are accepted by drop off and mail M-F 9am-5pm unless there is a closure. Contact us in advance to ensure the SHC will be open.

All shipped packages should be addressed as follows:

The College of William & Mary
Student Health Center
Attn: Student’s name
240 Gooch Drive
Williamsburg VA 23185

Thank you,

David Dafashy, MD
SHC Medical Director
**Allergen Immunotherapy Order Form**

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 will delay or prevent the patient from utilizing our services. This form can be delivered by the patient, mailed, or faxed or uploaded to the patient portal by the student.

Patient Name: ____________________________ Date of birth: ____________________________

Physician: ____________________________ Office phone: ____________________________ Fax: ____________________________

Office address: ____________________________

**I. PRE-INJECTION CHECKLIST:**

- Is peak flow required prior to injection? NO / YES If yes, peak flow must be >_________ to give injection.
- Is lung assessment required prior to injection? NO / YES
- Is student required to take antihistamine prior to injection? NO / YES
- Is student required to have epipen at the time of injection? NO / YES

**II. Injection Schedule:**

Date of Last Injection: _______________ Dose of Last Injection: _______________

Begin with __________(dilution) at _________ ml (dose) and increase every __________________ according to schedule below:

<table>
<thead>
<tr>
<th>Dilution</th>
<th>Contents</th>
<th>Color Vial</th>
<th>Expiration Dates</th>
<th>ml</th>
<th>ml</th>
<th>ml</th>
<th>ml</th>
<th>ml</th>
<th>ml</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>__ / __ / ___</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>__ / __ / ___</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>__ / __ / ___</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>__ / __ / ___</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>__ / __ / ___</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>__ / __ / ___</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>__ / __ / ___</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Go to next dilution  Go to next dilution  Go to next dilution  Go to next dilution  Go to next dilution

**III. MANAGEMENT OF MISSED INJECTIONS (according to number of days since LAST injection)**

During *Build Up* phase | After reaching *maintenance* |
---|---|
___ to ____ days continue as scheduled | ___ to ____ days give same dose |
___ to ____ days repeat previous dose | ___ to ____ weeks reduce by ___ ml |
___ to ____ days reduce by ___ ml | ___ to ____ weeks reduce by ___ ml |
Over ____ days - contact office for instructions | Over ____ weeks - contact office for instructions |

**IV. REACTIONS:**

Repeat dose if wheal is > __________ mm and < __________ mm

Reduce dose by one increment if wheal is > __________ mm

Other Instructions: ____________________________________________

Physician Signature: ____________________________ Date: ____________________________