Immunotherapy Orders

Please provide a new order for each new set of vials. Access the form at http://www.healthcenter.txstate.edu/forms
Fax completed orders to 512-245-9288.
Do not leave any blanks. Mark N/A if needed.

Office Name: ___________________________ Ph.# __________ Fax# __________
Address: ____________________________________________
          Street          City          State          Zip Code
Contact Person: ______________________________________

Patient Name: ___________________________ DOB __________ Tx. State ID # __________

Date: ________________________________ Number of Injections Given Each Visit: __________

1. Name of extract (vial)(s) ___________________________ Dilution/Strength: __________
                                ___________________________ Dilution/Strength: __________
                                ___________________________ Dilution/Strength: __________

2. Frequency of Injections: Every ________________ Days

3. Dose Schedule:
   Vial Name: _____ Vial Name: _____ Vial Name: _____
   Start With: _____ Start With: _____ Start With: _____
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____

   Vial Name: ___________________________ Maintenance Dose: _____ m.l. Frequency: _____ Days
   Vial Name: ___________________________ Maintenance Dose: _____ m.l. Frequency: _____ Days

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5. **Build-Up Phase:** Dose Adjustments for Unscheduled Gaps in Injection Intervals.

<table>
<thead>
<tr>
<th>Days since last injection</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________</td>
<td>continue as scheduled</td>
</tr>
<tr>
<td>__________</td>
<td>repeat previous dose.</td>
</tr>
<tr>
<td>__________</td>
<td>reduce dose by 25%</td>
</tr>
<tr>
<td>__________</td>
<td>reduce dose by 50%</td>
</tr>
<tr>
<td>__________</td>
<td>call allergist for orders</td>
</tr>
</tbody>
</table>

6. **Maintenance Phase:** Dose Adjustments for Unscheduled Gaps in Injection Intervals.

<table>
<thead>
<tr>
<th>Days since last injection</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________</td>
<td>continue as scheduled</td>
</tr>
<tr>
<td>__________</td>
<td>repeat previous dose.</td>
</tr>
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<td>__________</td>
<td>reduce dose by 25%</td>
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<tr>
<td>__________</td>
<td>reduce dose by 50%</td>
</tr>
<tr>
<td>__________</td>
<td>call allergist for orders</td>
</tr>
</tbody>
</table>

7. **Local Reaction Orders:**

<table>
<thead>
<tr>
<th>Wheal size</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>0—10 mm</td>
<td>Order ________</td>
</tr>
<tr>
<td>11—20 mm</td>
<td>Order ________</td>
</tr>
<tr>
<td>21—30 mm</td>
<td>Order ________</td>
</tr>
<tr>
<td>&gt;30 mm</td>
<td>Order ________</td>
</tr>
</tbody>
</table>

*Systemic reaction orders will be written by SHC physicians who are always present. The allergist will automatically be notified.

**Additional Instruction:**

8. Alternate Arms for Injections? (circle) Yes No
9. Take an antihistamine prior to injection? (circle) Yes No If yes, describe ____________________________
10. Patient must have an epinephrine pen with them? (circle) Yes No
11. Reduce dose with new vials? Yes No Explain Yes: ____________________________
12. Other Instruction: ____________________________________________________________

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**I understand that this will be the only physician’s order accepted by the SHC.**

Print Physician’s Name ____________________________  Physician’s Signature (Required)
Date: __________  TX License #: __________