PennState Student Affairs | University Health Services

Academic Year 2024-2025 Referring Allergist Agreement

Patients requesting allergy immunotherapy administration at Penn State University Health Services (UHS) are required to have their referring allergist complete this form.

Patient Name: _____ **Date of Birth**: _____

Note: Penn State University Health Services will not complete or sign any type of form from the referring allergist's office.

Forms are due annually. Please complete the entire form. Incomplete forms will result in a delay in treatment. We do our best to review orders and check serum in as soon as possible, however, due to a high volume of patients at the beginning of the semester, it is possible that there will be a 2-to-3-week delay from when we receive their serum/orders until we can schedule them, especially if the documentation we require is not complete.

Allergist Agreement:

My patient (printed name): _____ Date of Birth: _____, requests that Penn State University Health Services administer allergy extracts provided by my office.

Allergist Information:

Name:

_____

Allergist Office Address/Location:

_____

_____

Office Phone Number: _____ Office Fax Number: _____

Office Hours: _____

Allergist Orders: Please complete the entire form. Incomplete forms will result in a delay in treatment. We do not have an Allergist on premise. Our Allergy RN's follow your direct orders for your patient. All follow-up orders must be faxed, no verbal orders can be taken.

Patient has been receiving immunotherapy in my office since: _____

Has the patient had an anaphylactic reaction? ( ) Y ( ) N Date: _____

Description of anaphylactic reaction: _____

_____

Date of last injection: _____ **Note** If patient goes over 60 days without an injection, we require them to return to your office for the next injection. **

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Patient Name: _____ **Date of Birth**: _____

Diagnosis:

Asthma ☐ Y ☐ N Well controlled: ☐ Y ☐ N

Allergic Rhinitis: secondary to animal hair/dander ☐ Y ☐ N Secondary to pollen ☐ Y ☐ N

Acute Seasonal Allergic Rhinitis ☐ Y ☐ N

Allergic Rhinitis ☐ Y ☐ N

Toxic effects of Venom ☐ Y ☐ N

Please note if the following are required on injection days and any details of the order

Order	Yes	No	Details
EpiPen			
Oral Antihistamine			
Peak Flow *Extra charges may apply*			
Assess Lungs			
Ice Pack Use			
Inhaler Use			

While the patient is in the **building phase**, what is the **earliest time interval** they can receive injections?

_____

_____

While the patient is in **maintenance phase**, what is the **earliest interval** they can receive injections?

_____

_____

If a vial expires, how long after the expiration date can the serum be used? _____

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Patient Name: _____ **Date of Birth**: _____

Please make sure the following items are included in your orders. Incomplete orders will delay treatment.

1. Date of last injection
2. Frequency of injections
3. Dosing instructions
4. Serum concentration
5. Vials labeled clearly and correctly
6. Expiration dates noted
7. Late/missed injection orders
8. Local reaction orders and parameters

Medications patient is taking, including dosing and frequency (May attach medication list):

_____

_____

_____

_____

Other pertinent diagnoses/information:

_____

_____

_____

_____

Additional information you would like to provide:

_____

_____

_____

_____

Note: Penn State University Health Services is not responsible for the misinterpretation of the instructions provided with immunotherapy injections from the referring physician.

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Patient Name: _____ **Date of Birth**: _____

I Agree that:

I understand that I will continue to be responsible for the management of my patient's immunotherapy and modification of doses during therapy.

I understand that Penn State University Health Services does not have an Allergist on staff and that my orders are followed by Allergy RNs.

I will provide allergen immunotherapy extracts in adequately labeled vials for administration by the Allergy RNs at Penn State University Health Services.

Immunotherapy orders/instructions will be clear, detailed, and legible. I understand that unclear or illegible orders will result in a delay in treatment. I will be contacted by the Allergy Clinic RNs for clarification via fax.

I understand that NO verbal orders can be accepted. All orders must be faxed to the Allergy Clinic before they are carried out by the Allergy RNs. A delay in response to a fax will result in a delay in treatment.

I will provide all the information listed in this agreement. I understand if there is missing information, it will result in a delay in treatment for my patient.

Allergy injections are associated with some widely recognized risks. While most adverse reactions are local, there is a risk of severe anaphylactic reactions even with appropriately administered allergen immunotherapy; life-threatening and fatal reactions do occur. In the event a patient presents with an anaphylactic reaction, I understand the following emergency measures will be taken, as indicated:

- Epinephrine 0.3ml 1:1000 IM (may use Adult or Junior EpiPen as indicated)-can repeat at 5 to 15 minute intervals
- Benadryl 50 mg IM
- Oxygen via nasal cannula at 6-8 L/min
- IV Normal Saline wide open
- BP, pulse, respirations, and O2 Sat every 5 minutes
- Nebulizer treatment with Albuterol 0.083%, if indicated
- Solu-Medrol 125mg IV push over 1 minute, if indicated
- 911 called if Epinephrine is given

Referring Allergist Signature: _____ **Date**: _____

Referring Allergist Printed Name: _____

After completing, signing, and dating this form, please fax form to: ATTN: Allergy Nurse 814-863-3511