PennState Student Affairs | University Health Services

Referring Allergist Agreement

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

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

My Patient, (Name): _____ Date of Birth: _____, requests Penn State University Health Services administer allergy extracts provided by my office.

Allergist Information:

Allergist Name: _____

Allergist Office Address/Location: _____

Office Phone Number: _____ Office Fax Number: _____

Office Hours: _____

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 that contain the following, at a minimum: Patient first and last name, date of birth, contents of vials, dilution, and expiration date
- I will complete and sign off on all orders in this form. I understand if there are missing orders, it will result in a delay in treatment for my patient. Failure to utilize the attached, standardized best practice format will result in the patient not being seen. NOTE: In keeping with the practice of other Big Ten universities and standardization, this Penn State form must be completed by the allergist.
- I understand that Penn State University Health Services will not complete or sign any form from the referring allergist's office related to acceptance of the serum.
- 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. This form must be completed annually or when orders change.
- **I understand that verbal orders are not accepted. All orders must be faxed to the Allergy Clinic (814-863-3511) before they are carried out by the Allergy RNs. A delay in response to a fax will result in a delay in treatment.**

Please complete the entire form.

Referring Allergist Signature: _____ Date: _____

Referring Allergist Printed Name: _____

Referring Allergist Agreement

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

Diagnosis
This is treatment for (circle all that apply):

Asthma Allergic Rhinitis Toxic Effects of Venom Other (Please List): _____

Please note if any of the following are required on injection days:

Order	Yes	No	Details
EpiPen *			
Oral Antihistamine			
Peak Flow (Extra charges may apply)			
Assess Lungs			

* If an EpiPen is ordered, the patient MUST have their own EpiPen that MUST be presented to the allergy nurse prior to each injection. If they fail to carry their EpiPen, they will not receive their injection and must reschedule for a later time.

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?

_____

Additional Information:

_____

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Injection Schedule
Begin with __________(dilution) at _________mL (dose) and increase according to the schedule below. Increase according to schedule every _________ to _________ DAYS / WEEKS (circle one). Once maintenance dose of _________mL is reached, repeat maintenance dose of ______ mL every ______ DAYS / WEEKS (circle one).

The patient is currently undergoing BUILD-UP / MAINTENANCE therapy (circle one).

Vial # **Color** **Dilution**	**Vial #** **Color** **Dilution**	**Vial #** **Color** **Dilution**	**Vial #** **Color** **Dilution**	**Vial #** **Color** **Dilution**	**Vial #** **Color** **Dilution**
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	mL	mL	mL	mL	mL
mL	mL	mL	mL	mL	mL
mL	mL	mL	mL	mL	mL

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Below is the schedule UHS follows for late dosage adjustments for buildup and maintenance schedules. Please review and sign at the bottom of the page.

Build Up Schedule
Dosage Adjustments for late injections, based on length of time IN DAYS **since last injection was due**.

Build Up Schedule Missed Injections
Please complete the left side of the chart in DAYS. Attached protocols will not be accepted.

Time Since Last Injection was Due in DAYS	Dose Recommendation
	Continue to increase per schedule.
	Repeat last dose, then continue schedule.
	Reduce dose by 1 step, then continue per schedule.
	Reduce dose by 2 steps, then continue per schedule.
	Reduce dose by 3 steps, then continue per schedule.
	Call the allergist office for further instructions.

** UHS policy states that during build-up therapy, if a patient does not receive an injection for 60 days or longer, they must return to their Allergist office to receive their next dose before returning to the UHS Allergy Clinic.

Additional Information

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_____

Maintenance Schedule
Maintenance schedule is calculated from **when the injection was due, IN DAYS**, not when it was last administered. **Please complete the left side of the chart in DAYS. Attached protocols will not be accepted**.

Time Since Last Injection was Due in DAYS	Dose Recommendation
	Repeat last dose
	Reduce dose by 1 step.
	Reduce dose by 2 steps.
	Reduce dose by 3 steps.
	Call the allergist office for further instructions.

Additional Information

_____

_____

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Patients are required to wait 30 minutes after receiving an allergy injection. After 30 minutes, they are required to report to the Allergy RN for an assessment of the injection site. The following are the parameters UHS follows for reactions.

Minor local swelling and itching is common. **Reactions are based on the following wheal/swelling:**

- For local reactions <30mm, give the next dose as scheduled.
- For local reactions of 30-40mm repeat the same dose.
- For reactions greater than 40mm, reduce dose one increment.
- For any reactions that produce a local reaction needing repeat of a dose or dose adjustment:
    - If repeat of the dose/reduction of dose produces a reaction < 30mm, we proceed to the next dose.
    - If this adjustment continues to produce a reaction ≥ 30mm, contact our office.

- **Wheal and/or swelling up to 30mm**: Proceed with schedule.
- **Wheal >30mm and/or swelling that lasts up to 24 hours**: Repeat last dose.
- **Wheal and/or swelling that lasts over 24 hours**: Call/fax Allergist office to receive orders on how to proceed for the next injection. NO further injections will be given without a faxed, written order. NO verbal orders are accepted.

Additional Information

_____

_____

All orders must be typed or written legibly. Failure to do so may lead to a delay in treatment and patients missing their next scheduled dose.

I agree to the above orders.

Referring Allergist Signature: _____ Date: _____

Referring Allergist Printed Name: _____

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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 that all or part of the following emergency measures may be taken, as necessary:

- 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 or IV
- 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
- Transport to the nearest hospital

Referring Allergist Signature: _____ Date: _____

Referring Allergist Printed Name: _____

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

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