KENT STATE UNIVERSITY | University Health Services

PATIENT'S NAME: _____

DATE OF BIRTH: _____

ALLERGY INJECTION GUIDELINE

Information and instructions for the continuation of immunotherapy injection(s) at Kent State University Health Services.

Prior to receiving allergy injections at UHS, patients must be established with a UHS clinician.
NO verbal orders for dosage adjustments will be accepted. All changes must be faxed to University Health Services and be signed by the allergist.

WRITTEN INSTRUCTIONS/Flow Sheets from the allergist **must** contain the following:
☐Date, dosage, and reaction to last injection-
☐Patient name and DOB
☐ Documented proof that the patient has received the first injection from the vial at the allergist's office
☐Dosage schedule
☐ Frequency of injections
☐ Adjustment of dose for local reaction
☐Adjustment of dose for missed or late injections
☐ Allergist's office address, telephone number, and fax number
☐**Signature of physician**

DX Code:
☐ **J30.1** Allergic rhinitis due to pollen
☐ **J30.2** Other seasonal allergic rhinitis
☐ **J30.89** Other allergic rhinitis
☐ **J30.9** Allergic rhinitis, unspecified
☐ **J45.20** Mild intermittent asthma, uncomplicated
☐ **J45.909** Unspecified asthma, uncomplicated
☐ **J45.998** Other asthma
☐ **J30.81** Allergic rhinitis due to animal (cat) (dog) hair and dander
☐ **Other _____**

ALLERGEN EXTRACT VIALS must be labelled with the following:
☐ Patient's full name and D.O.B.
☐ Contents of each vial
☐ Strength of each vial
☐ Expiration date of each vial

Your signature below reflects that you have given permission for your patient to have allergy injections administered at the Kent State University DeWeese Health Center by a registered nurse. A physician or nurse practitioner is on-site at all times. Our standard anaphylaxis reaction policy will be followed in the event of a systemic reaction.

Print Allergist's Name:_____

Allergist's Signature **(REQUIRED):**_____DATE:_____

ADDRESS:_____

PHONE:_____FAX:_____

Kent State University DeWeese Health Center
1500 Eastway Dr
Kent, OHIO 44242-0001
Phone: (330)672-2322 Fax: (330)672-2272 Immunization/Allergy Clinic: (330)672-8231

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