Duke Student Health Allergy Clinic (DSHAC)
DUMC Box 2899
Duke University Medical Center
Durham, NC 27710
Telephone 919-681-2465 Fax 919-681-5384

REQUEST FOR ALLERGY IMMUNOTHERAPY
INITIATED BY NON-STUDENT HEALTH SERVICES PHYSICIAN
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TO PATIENT:

The Duke Student Health Center will assist you in receiving allergy immunotherapy initiated by a non-Student Health Service physician (i.e. "your allergist") while you are a patient here. Your allergist remains your physician in relation to the condition which you are being treated. Therefore, we must have detailed information and instructions from your physician regarding this condition and covering all circumstances that may arise. It is you and your private physician's responsibility to supply the medication(s) to be used. Injections will not be given if instructions are inadequate. We cannot be responsible for breakage or loss of medication(s). At any time the DSHAC may decline or withdraw a student's eligibility in participation in the DSHAC.

Your private medical provider (MD, DO, PA, and NP) cannot be someone with whom you have a significant emotional relationship (e.g. parent, sibling, or other relative).

TO PHYSICIAN:

This patient has requested the Duke Student Health Allergy Clinic (DSHAC) give him/her allergen immunotherapy previously initiated by you. Our guidelines for the administration of allergen immunotherapy require that the prescribing allergist provide our office with the following:

1. **Allergy extracts that are properly labeled with antigen content, concentration and the expiration date. The DSHAC Nurse must use the actual date written on the vial as the actual expiration date. The Nurse cannot take written/verbal orders to extend the expiration date.**
2. **Decisions regarding dose intervals, quantity and changes in dosing due if patient is late for an injection or due to reactions to the drug must come from you. Therefore, we need precise information from you and request that you complete the following data sheet. If issues develop that are not answered by the information you give us, we will contact you for further instructions.**
3. **We require written signed orders when we administer medication from a non Student Health physician. We cannot begin giving injections without receiving the enclosed form completed with a legible printed name and signature.**

We, in turn, will give the patient a copy of his/her injection record, if requested, when he/she returns to your care. The medications are given by a Registered Nurse and there is a physician on-site.

We look forward to assisting you in caring for your patient.

Melanie Trost, MD
(919) 681-2465
Duke Student Health Services

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REQUEST FOR ALLERGY IMMUNOTHERAPY
INITIATED BY NON-STUDENT HEALTH SERVICES PHYSICIAN
[This is a 3 page document, page 2/3]

Patient Name: _____ Date: _____

DOB: _____ MR#: _____

NOTE: This information must be provided in detail before allergen extracts will be administered at Duke Student Health. If you are sending attachments please insure that they include a printed physician name and are individually signed.

1. Detailed administration schedule for buildup and maintenance that clearly references appropriate vial and vial contents.

2. Instructions on how to adjust dosage's following a local reaction

3. Instructions on how to adjust dosage if patient is late for injection(s) or deviates from his/her schedule (based on the time lapse after last injection(s)), the instructions must be specific especially if the patient is on a build-up cycle:

4. Instruction regarding adjustment of dosage when starting a new maintenance vial:

5. Specific guidelines regarding when to withhold or reduce dosage with illness, wheezing or increased allergy symptoms:

6. History of chronic or severe illness which might affect general health or desensitization schedule:

7. History of previous significant local or systemic reactions to allergy immunotherapy including type of reaction, what extract(s) and previous treatment for adverse reaction:

8. Current or prior use of beta blocker.

9. Other comments or instructions:

Physician Signature:_____

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PHYSICIAN ACKNOWLEDGEMENT

My signature below acknowledges that Duke Student Health Allergy Clinic (DSHAC) will administer allergen immunotherapy and management of both local and systemic reactions to allergen immunotherapy; (2) that clear and explicit instructions as outlined in the Request For Allergy Immunotherapy Initiated By Non-Student Health Services Physician must be provided by me prior to administration [page #2 of this document]; (3) that extract vials must be hand delivered by the patient and may not be mailed or directly forwarded to DSHAC; (4) that I or my staff will be available for phone consultation as needed; (5) that the patient may return to my office at any time for continuation of immunotherapy if so requested by DSHAC or the patient.

Acknowledged and agreed to by:

Signature: _____

Physician name: _____

Address: _____

_____

_____

Phone: _____

Fax: _____

E-mail (if available): _____

Website (if available): _____