The University of North Carolina at Chapel Hill
Division of Student Affairs Campus Health Services
CB# 7470
Chapel Hill, NC 27599-7470
Telephone 919/966-2281
Fax 919/966-0616

REQUEST FOR PARENTERAL (INJECTION) THERAPY ORDERED BY NON-CAMPUS HEALTH SERVICES PHYSICIAN

TO PATIENT:

The Campus Health Services desires to assist you in receiving allergy immunotherapy ordered by a non-Campus Health Service physician while you are a patient here. We do this by serving temporarily as the agent of that physician. He/she remains, in effect, your physician in relation to the condition for 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 your and your 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).***

TO PHYSICIAN:

This patient has requested the Campus Health Services give him/her allergen immunotherapy ordered by you. We are pleased to do this in the capacity of an agent for you. We require you to supply the medication(s) and we supply disposable syringes and needles. **Allergy extracts must be properly labeled with patient name, date of birth, antigen content, concentration and the expiration date. The Registered Nurse must use the date written on the vial as the actual expiration date. The Nurse cannot take verbal orders to extend the expiration date.** The medications are given by a Registered Nurse and there is a physician available when there are any untoward reactions requiring immediate medical care.

Any decision 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 we request that you complete the following data sheet. Please note that "See Attached" is not acceptable. If problems develop that are not answered by the information you give us, we will contact you for further instructions.

In setting up your orders for Campus Health Services, please keep in mind times such as semester and summer breaks when your patient will not be at the University of North Carolina at Chapel Hill and instruct him/her and us accordingly. We require written orders when we administer medication from a physician located elsewhere. We cannot begin giving injections without receiving the enclosed form, both completed and signed by you. We, in turn, will give the patient a copy of his/her injection record, if requested, when he/she returns to your care. ***Procedures that are not performed at the Campus Health Services are vial testing and addition of epinephrine or normal saline to injections. If either of these is necessary in the administration of allergy injections for the student, he/she will need to locate a medical provider who can provide these services.***

We look forward to assisting you in caring for your patient.
Joan G. Potter, M.D.
Director of Clinical Services

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ORDERED BY NON-CAMPUS HEALTH SERVICES PHYSICIAN

PLEASE PRINT

_____ _____ _____
Patient's Name Date of Birth Date

NOTE: This form must be completed in detail before allergen extracts will be administered at Campus Health Services. Please do not write "See Enclosed Instructions."

In order to better serve your patient, we are requesting the following information be completed. Please note that reference to "see attached documentation" will not be accepted.

Patient ☐ needs to carry epi-pen day of injection
☑ does not need to carry epi-pen

Patient ☐ needs peak flow prior to injection
☐ does not need peak flow
☑ hold if peak flow < _____

Patient ☐ needs to premedicate with _____
☑ does not need to premedicate

Build-Up
During build-up, ☐ See Shot Record
Late schedule doses decreased by _____mL

Build-up dosing:

Must have ____ days between injections
May increase dosage up to ____ days since last injection

____to____days since last injection = REPEAT DOSE
____to____days since last injection = drop back 1 dose
____to____days since last injection = drop back 2 doses
over ____days = call allergist office

Maintenance
Maintenance dose is _____mL every ____days or ____weeks of _____concentration/Vial # and at least _____days between doses.

New maintenance vial: drop back ____ doses from previous vial
Increase by ____mL every _____days
No more than ____ days between an increased dose

Late schedule for maintenance dosing: must be at least ____days or ____ weeks since last injection

Days since last injection:
Up to_____ days, no change
Day___ through day _____, drop back _____ dose(s) or _____ mLs
Day___ through day _____, drop back _____ dose(s) or _____ mLs
Day___ through day _____, drop back _____ dose(s) or _____ mLs
Over _____ days call office

1. Please define grades of local reactions in term of redness and/or swelling/wheal and any dose adjustments

2. Specific guidelines for dosage adjustment:

   Illness: _____(specify illness)
   ☐ withhold
   ☐ decrease dose by ____mL

   Wheezing:
   ☐ withhold
   ☐ decrease dose by ____mL

   Increased allergy symptoms:
   ☐ withhold
   ☐ decrease dose by ____mL

   Use of antibiotics:
   ☐ withhold
   ☐ may receive allergy injection(s)

3. Has the patient experienced previous significant local or systemic reactions to allergy extracts?

   ☐ YES ☐ NO

   If YES, indicate type of reaction, what extract(s) and previous treatment for adverse reaction:

4. Is patient taking any Beta-Blockers? ☐ YES ☐ NO

NOTE: A ☐ 20 ☐ 30 minute waiting time after injection(s) will be enforced.

_____	_____
Physician's Signature	Street Address
_____	_____
Physician's Name (please print)	City State Zip Code
(_____)_____	(_____)_____
Fax Number	Telephone Number

UNC CHS: 09/09
Revised: 3/11