Allergist's Order Sheet

INDIANA UNIVERSITY STUDENT HEALTH CENTER

600 N. JORDAN AVENUE, BLOOMINGTON, INDIANA 47405

PHONE: 812-855-7514 FAX: 812-856-8729

Rev. 1/16

Patient Name:	
DOB:	
Allergist:	

Orders From Allergist:

EPI Pen Required To Receive Allergy Injections!

Does Patient have **Asthma**? Y N	**Antihistamine** required on Injection Day? Y N
Peak Flow with each injection: Y N	Pt can receive **Vaccine** on same day as allergy injection Y N
Baseline Peak Flow =	Date of Last Allergy Injection:
80% of Predicted Peak Flow =	Dose: Reaction:
Allergy injections should be held if PF < 80% Y N	

Vial Name:	Vial Name:	Vial Name:	Vial Name:	Vial Name:	**Special Instructions:**
Dilution:	Dilution:	Dilution:	Dilution:	Dilution:	
Vial Top Color:	Vial Top Color:	Vial Top Color:	Vial Top Color:	Vial Top Color:	
0.____ml	0.____ml	0.____ml	0.____ml	0.____ml	
0.____ml	0.____ml	0.____ml	0.____ml	0.____ml	
0.____ml	0.____ml	0.____ml	0.____ml	0.____ml	
0.____ml	0.____ml	0.____ml	0.____ml	0.____ml	
0.____ml	0.____ml	0.____ml	0.____ml	0.____ml	
0.____ml	0.____ml	0.____ml	0.____ml	0.____ml	
0.____ml	0.____ml	0.____ml	0.____ml	0.____ml	
0.____ml	0.____ml	0.____ml	0.____ml	0.____ml	
0.____ml	0.____ml	0.____ml	0.____ml	0.____ml	
0.____ml	0.____ml	0.____ml	0.____ml	0.____ml	

When to order new serum:

Missed Scheduled injection Guidelines:	
Days Since Last Shot:	Order:
(ex: 7-14 days)	(ex: Proceed per schedule)

Guidelines based on local reaction size:	
Reaction size:	Order:
(ex: <15mm /Dime size)	(ex: Proceed to build)

***Allergist will be called for orders if systemic reaction occurs.**