

## Referring Allergist Agreement

### Instructions for the Referring Allergist:

- Complete and sign the Referring Allergist Agreement Form (below)
- Complete **Allergist Order Sheet** (PDF @ [www.healthcenter.indiana.edu](http://www.healthcenter.indiana.edu) Click on Download Forms)
- Complete **Allergy Patient Dosage Recording Sheet** (PDF @ [www.healthcenter.indiana.edu](http://www.healthcenter.indiana.edu) Click on Download Forms)
- Review our **Allergy Clinic Policies and Procedures** which includes our protocol for management of anaphylaxis and systemic reactions. [www.healthcenter.indiana.edu/services/allergy](http://www.healthcenter.indiana.edu/services/allergy)

### Allergist Agreement

My patient, \_\_\_\_\_, is requesting the Indiana University Health Center (IUHC) administer allergy extracts provided by my office.

#### I agree to the following:

- I will provide allergen immunotherapy extract in adequately labeled\* vials for administration at IUHC.  
\*Patient name, antigen(s) name, dilution, expiration date
- I will provide detailed directions regarding dosage schedule for buildup phase and/or maintenance by **completely** filling out the **Allergist Order Sheet** and the **Patient Dosage Recording Sheet** provided by IUHC.
- I will provide detailed directions regarding dosage/schedule adjustments that might be necessary due to patient missing scheduled injections or due to local or systemic reactions by **completely** filling out the **Allergist Order Sheet** and the **Patient Dosage Recording Sheet** provided by IUHC.
- I will continue to be responsible for the management of this patient's immunotherapy and for the modification of doses during therapy.
- I will be available by phone to the nurses and providers at IUHC should questions or problems arise with this patient's immunotherapy.
- I understand that IUHC requires **all** patients to have an **Epi Pen** with them in order to receive their allergy injections.
- I have read the IUHC **Policy and Procedures for Allergy Immunotherapy** including the protocol for management of anaphylaxis and systemic reactions and agree that they provide adequately for the care and safety of my patient. [www.healthcenter.indiana.edu/services/allergy](http://www.healthcenter.indiana.edu/services/allergy)

Referring Allergist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Allergist Name Printed: \_\_\_\_\_