INDIANA UNIVERSITY HEALTH CENTER
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Dr. Beth Rupp MD
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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 Click on Download Forms)
- Complete **Allergy Patient Dosage Recording Sheet** (PDF @ 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

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

Referring Allergist Name
Printed:_____

Referring Allergist
Signature:_____Date:_____