Allergist's Order Sheet

INDIANA UNIVERSITY STUDENT HEALTH CENTER

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Rev. 1/16

Patient Name:	
DOB:	
Allergist:	

Orders From Allergist:

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 ☐	

EPI Pen Required To Receive Allergy Injections!

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.**