

## Immunotherapy Orders

**Please provide a new order for each new set of vials. Access the form at <http://www.healthcenter.txstate.edu/forms/ImmunotherapyOrders.pdf>**

**Fax completed orders to 512-245-9288.  
Do not leave any blanks. Mark N/A if needed.**

Office Name: \_\_\_\_\_ Ph.# \_\_\_\_\_ Fax# \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Contact Person: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Tx. State ID #** \_\_\_\_\_

Date: \_\_\_\_\_ Number of Injections Given Each Visit: \_\_\_\_\_

1. Name of extract (vial)(s) \_\_\_\_\_ Dilution/Strength: \_\_\_\_\_  
\_\_\_\_\_ Dilution/Strength: \_\_\_\_\_  
\_\_\_\_\_ Dilution/Strength: \_\_\_\_\_

2. Frequency of Injections: Every \_\_\_\_\_ Days

3. Dose Schedule:

|                   |                   |                   |
|-------------------|-------------------|-------------------|
| Vial Name: _____  | Vial Name: _____  | Vial Name: _____  |
| Start With: _____ | Start With: _____ | Start With: _____ |
| _____             | _____             | _____             |
| _____             | _____             | _____             |
| _____             | _____             | _____             |
| _____             | _____             | _____             |
| _____             | _____             | _____             |
| _____             | _____             | _____             |
| _____             | _____             | _____             |
| _____             | _____             | _____             |
| _____             | _____             | _____             |

4. Vial Name: \_\_\_\_\_ Maintenance Dose: \_\_\_\_\_ m.l. Frequency: \_\_\_\_\_ Days.  
Vial Name: \_\_\_\_\_ Maintenance Dose: \_\_\_\_\_ m.l. Frequency: \_\_\_\_\_ Days  
Vial Name: \_\_\_\_\_ Maintenance Dose: \_\_\_\_\_ m.l. Frequency: \_\_\_\_\_ Days

5. **Build-Up Phase:** Dose Adjustments for Unscheduled Gaps in Injection Intervals.

- \_\_\_\_\_ days since last injection: continue as scheduled
- \_\_\_\_\_ days since last injection: repeat previous dose.
- \_\_\_\_\_ days since last injection: reduce dose by 25%
- \_\_\_\_\_ days since last injection: reduce dose by 50 %
- \_\_\_\_\_ days since last injection: \_\_\_\_\_
- \_\_\_\_\_ days since last injection: call allergist for orders

6. **Maintenance Phase:** Dose Adjustments for Unscheduled Gaps in Injection Intervals.

- \_\_\_\_\_ days since last injection: continue as scheduled
- \_\_\_\_\_ days since last injection: repeat previous dose.
- \_\_\_\_\_ days since last injection: reduce dose by 25%
- \_\_\_\_\_ days since last injection: reduce dose by 50%
- \_\_\_\_\_ days since last injection: \_\_\_\_\_
- \_\_\_\_\_ days since last injection: call allergist for orders

7. **Local Reaction Orders:**

- 0—10 mm wheal: Order \_\_\_\_\_
- 11—20 mm wheal: Order \_\_\_\_\_
- 21—30 mm wheal: Order \_\_\_\_\_
- >30 mm wheal: Order \_\_\_\_\_

\*Systemic reaction orders will be written by SHC physicians who are always present. The allergist will automatically be notified.

Additional Instruction: \_\_\_\_\_

- 8. Alternate Arms for Injections? (circle) Yes No
- 9. Take an antihistamine prior to injection? (circle) Yes No  
If yes, describe \_\_\_\_\_
- 10. Patient must have an epinephrine pen with them? (circle) Yes No
- 11. Reduce dose with new vials? Yes No Explain Yes: \_\_\_\_\_
- 12. Other Instruction: \_\_\_\_\_  
\_\_\_\_\_

**I understand that this will be the only physician's order accepted by the SHC.**

\_\_\_\_\_  
Print Physician's Name  
Date: \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature (Required)  
TX License #: \_\_\_\_\_