University Health Service’s (UHS) goal is to provide the safest care possible for our patients.

In order for student patients to receive allergy serum injections at University Health Service Allergy Clinic, please review and adhere to the requirements listed below:

1) Every patient’s initial injection(s) must be performed at their allergist’s office.
2) We do not mix or dilute any extracts; this must be done by the prescribing allergist. We will store extracts in UHS Allergy Clinic.
3) We do not give insect venom.
4) Each vial must be clearly labeled with the following upon receipt:
   a. Patient’s name
   b. Name of the antigen(s)
   c. Dilution
   d. Expiration date
5) The University Health Service Standardized Allergy Form MUST be completed and provided to our Allergy Clinic prior to a student patient receiving injections.
6) UHS prefers that all allergy extracts and materials be hand carried to the clinic by the patient.
7) Mailing address: UHS, 830 S. Limestone, Lexington, KY 40536-0582

These requirements are for the safety of our student patients. Failure to comply may delay and potentially prevent utilization of this service. We appreciate your assistance in helping us safely care for your allergy patient.

Sincerely,

Ann Hays, MD
Clinical Director, University Health Service
For your patient’s safety, and to facilitate the transfer of allergy treatment to University Health Service, completion of this form is required. This form can be delivered by the patient, mailed to the UHS Allergy Nurse at 830 S. Limestone, Lexington, KY 40536, or faxed to 859-257-9809 (attention UHS Allergy Nurse).

Patient Name: ___________________________ Date of Birth: ___________________________
Physician: ___________________ Phone: __________________ Fax: __________________
Address: ___________________________

PRE-INJECTION CHECKLIST:
- Is peak flow required prior to injection? ☐ Yes ☐ No
  If yes, peak flow should be >_______ to proceed with injection.
- Is patient required to have taken an antihistamine prior to injection? ☐ Yes ☐ No
- Is patient required to have an Epinephrine pen? ☐ Yes ☐ No
- Alternate arms for injection site? ☐ Yes ☐ No

INJECTION SCHEDULE:
Begin with ________________________(Vial Dilution and Dose) and increase according to the schedule by ________________________ until a maximum tolerated dose ________________________ can be achieved.

<table>
<thead>
<tr>
<th>Dilution/Color</th>
<th>Expiration Date(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>/<strong><strong>/</strong></strong></td>
</tr>
<tr>
<td></td>
<td>/_____/____</td>
</tr>
<tr>
<td></td>
<td>/<strong><strong>/</strong></strong></td>
</tr>
<tr>
<td></td>
<td>/<strong><strong>/</strong></strong></td>
</tr>
</tbody>
</table>

Go to next Vial(Color)

Go to next Vial(Color)

Go to next Vial(Color)

Go to next Vial(Color)

MANAGEMENT OF MISSED INJECTIONS: (According to # of days from LAST injection)

During Build-Up Phase | After Reaching Maintenance

- ____ to _____ days – continue as scheduled
- ____ to _____ days – repeat previous dose
- ____ to _____ days – reduce previous dose by 25%
- ____ to _____ days – reduce previous dose by 50%
- Over _____ days – contact office for instructions

- ____ to _____ days – give same maintenance dose
- ____ to _____ weeks – reduce dose by 25%
- ____ to _____ weeks – reduce dose by 50%
- Over _____ weeks – contact office for instructions

REACTIONS:
At next visit: Repeat dose if swelling is >___________ mm and <___________ mm.
Reduce by one dose if swelling is >___________ mm.

Other Instructions: ___________________________

__________________________  ____________________________
Physician Signature: Date: