James Madison University Health Center 724 S. Mason St. MSC 7901 Harrisonburg, VA 22807



The James Madison University Health Center's goal is to provide care needed by our student patients in the safest way possible. Your assistance with this goal is not only required but also greatly appreciated.

Our Allergy Clinic now serves over 200 student patients referred by over 80 different allergy specialists. Each allergy specialist has a unique form they use in their office. As you can imagine, utilizing over 80 different forms is very challenging and has significant potential for error. Therefore, to maximize the safety margin for the student patients, our clinic has developed an allergy immunotherapy administration form that we will utilize for every student patient in our allergy clinic.

In order for student patients to receive allergy immunotherapy at the JMU Health Center Allergy clinic, we require the following:

- 1) Every student patient's initial injection(s) must be performed at the Allergist's office.
- 2) We will not mix or dilute any extracts; this must be done by the prescribing allergist. We will store extracts in the Allergy clinic.
- 3) Each vial must be clearly labeled with:
 - a. Patient's name
 - b. Name of the antigen(s)
 - c. Dilution
 - d. Expiration date
- 4) The James Madison University Health Center Allergy Immunotherapy administration form MUST be completed and provided to the Allergy clinic prior to a student patient receiving injections.
- 5) There is a charge associated with injections. While we do not participate in or bill any insurance plans, we do provide receipts to submit to insurance companies for reimbursement. Please visit the JMU Health Center website https://www.jmu.edu/healthcenter/StudentCare/allergy.shtml.

These requirements are purely for the safety of our student patients. Failure to comply could delay and potentially prevent utilization of our services.

Sincerely,

Andrew T. Guertler, MD

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Medical Director

James Madison University Health Center

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JAMES MADISON UNIVERSITY HEALTH CENTER

724 S. Mason St. MSC 7901, Harrisonburg, VA 22807 **Secure FAX:** 540-568-6176



Allergen Immunotherapy Order Form

For your patient's safety and to facilitate the transfer of allergy treatment to our clinic, this form must be completed to provide standardization and prevent errors. Failure to complete this form will delay or prevent the patient from utilizing our services. Form can be delivered by the patient, mailed or faxed (see address and fax above). Patient Name: _____ Date of Birth: _____ Office Phone: ______ Secure Fax:_____ Physician: _____ Office Address: PRE-INJECTION CHECKLIST: ■ Is peak flow required prior to injection? NO YES If yes, peak flow must be ≥ _____L/min to give injection. ■ Is student required to have taken an antihistamine prior to injection? NO YES **INJECTION SCHEDULE:** Begin with ______ (dilution) at _____ml (dose) and increase according to the schedule below. Dilution Vial Cap Color Expiration Date(s) ml Go to next Dilution Go to next Dilution Go to next Dilution Go to next Dilution ml **MANAGEMENT OF MISSED INJECTIONS:** (According to number of days from *LAST* injection) **After Reaching Maintenance During Build-Up Phase** to days – continue as scheduled ■ to days – give same maintenance dose ■ ____ to ____ days – repeat previous dose to _____ to ____ weeks – reduce previous dose by _____ (ml) to days – reduce previous dose by (ml) to weeks – reduce previous dose by (ml) ■ ____ to ____ days – reduce previous dose by (ml) Over ____ weeks – contact office for instructions Over days – contact office for instructions **REACTIONS:** At next visit: Repeat dose if swelling is > mm and < mm. Reduce by one dose increment if swelling is > _____mm.

Date: _____

Physician Signature: ______

Other Instructions: