Texas State University-San Marcos
Student Health Center, 601 University Dr., San Marcos, TX. 78666
Ph. # 512-245-2161; Fax 512-245-9288

Immunotherapy Orders

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

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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	Physician's Signature (Required)
Date:__________	TX License #:_____________