

Allergy Clinic

(850) 644-9492 ph 1-888-355-7303 fax

Outside Order to Administer Allergy Injections

Patient Name & DOB: _____ **Date:** _____

The patient named above is currently under my care for the treatment of _____
_____.

I authorize University Health Services (UHS) Allergy Clinic at Florida State University to administer allergy immunotherapy injections from the allergy serum vials provided by my office, as per my orders and instructions. I understand the patient must have received their first immunotherapy injection at my office, under my supervision. I understand UHS will follow internal protocols for the management of systemic reactions and will only document on internal forms. I understand the reordering of allergy serum is the responsibility of the patient. I further understand UHS Allergy Clinic will release allergy serum to patients upon their request, and instruct them to notify their allergist when signing out vials. The patient will continue to follow up with me as directed.

1. The missed injection schedule provided begins from date of last injection / last day of injection window (please circle one).
2. Is this patient required to carry an Epi Pen on injection day? Yes/No (please circle one)
3. Does this patient require antihistamine prior to injection? Yes/No (please circle one)
4. Does this patient require pre/post peak flows? Yes/No (please circle one)

Applicable ICD-10 codes: _____

Allergist Office Information

Name of Practice: _____

Address: _____

Phone Number: _____

Fax Number: _____

Allergy Clinic Nurse/Contact: _____

Prescribing Allergy Physician Signature/Credentials

Printed Name

Date

960 Learning Way, Tallahassee, FL 32306-4178

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