UNIVERSITY HEALTH SERVICES
HEALTH & WELLNESS CENTER at FSU

Allergy Clinic

(850) 644-9492 ph (850) 644-3379 fax

Outside Order to Administer Allergy Injections

Patient Name: __________________________ **Date: ____________________**

Patient Date of Birth: ___________________

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 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.

The missed injection schedule provided begins from date of last injection / last day of injection window (please circle one).

Applicable ICD-10 codes: ____

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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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