Allergy Desensitization Form

History & Instructions From Ordering Physician, NP or PA

This form must be completed in full prior to starting allergy injections at University Health Services. Vials must be clearly labeled and correspond with the written instructions and dosage sheets. Prescribing Provider must provide dosage adjustment instructions for missed/late injections and local reactions.

UHS ALLERGY/IMMUNIZATION CLINIC INFORMATION:
Contact Information: Office 512-475-8301, Fax 512-471-7119
Mailing Address: UT Austin, University Health Services, ATTN: A/I Clinic, 100 West Dean Keeton STOP A3900, Austin, TX 78712
Location: Student Services Building (SSB) 2.102

PRESCRIBING PROVIDER INFORMATION:
Name: 
Address: 

OFFICE PHONE NUMBER
OFFICE FAX NUMBER
OFFICE HOURS

PATIENT INFORMATION:
Name: ____________________________ Date of Birth: ____________________________

Patient has been receiving immunotherapy in my office since (date): ____________________________

Patient has had a systematic reaction in the past. 
If yes, date and description: ____________________________

Oral antihistamine required before injection. ____________________________

Patient required to carry their own epinephrine auto-injector on shot days in case of reaction after leaving the allergy clinic. ____________________________

Patient has asthma. ____________________________

Patient required to take maintenance asthma medication/inhaler to receive injections. 
If yes, list drug/instructions: ____________________________

Patient required to have Peak Flow measured.* 
If yes, before/after injection (circle). ____________________________
Minimum Peak Flow to receive injections: ____________
Patient’s personal best PF: ____________
*not performed in the clinic until further notice due to COVID-19

Patient permitted to have flu vaccine at same visit as allergy injections. ____________________________

Medications patient is taking, dosage, frequency (attach medication list if necessary):

__________________________

Other pertinent diagnosis: ____________________________

Please attach the last office visit progress note.

I request that University Health Services administer allergy immunotherapy to this student according to the instructions and schedules submitted by me.

PHYSICIAN, NP, OR PA PRINTED NAME ____________________________ PHYSICIAN, NP, OR PA SIGNATURE ____________________________ DATE ____________________________

UHS Staff Review: ____________________________

UHS NURSE SIGNATURE ____________________________ DATE ____________________________

FORM - Allergy Desensitization Form - 07/01/2021