healthyhorns
University Health Services

Allergy Desensitization Form
History & Instructions From Ordering Physician, NP or PA

This form must be completed in full and submitted with a copy of the most recent office visit note, prior to starting injections at UHS.

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.

If a patient exhibits signs of a systemic reaction post injection, UHS will immediately initiate our medical emergency response protocol for evaluation and management of the reaction. Additional injections will not be administered without contacting the prescribing allergist.

The national guidelines for allergy injections recommend immunotherapy be given under qualified medical supervision. UHS will not accept patients who do not follow this guideline.

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:

Licensed: ☐ Physican ☐ Physician Assistant ☐ Nurse Practitioner ☐ *N/A not licensed in Texas

NAME ______ TEXAS LICENSE NUMBER ______ ADDRESS ______

OFFICE FAX NUMBER ______ OFFICE PHONE NUMBER ______ OFFICE HOURS ______

**IMPORTANT: UHS will assist students to establish with a local provider if their allergist is not authorized to practice in Texas.*

PATIENT INFORMATION:

Name: ______ **Date of Birth:** ______

- **Patient has been receiving immunotherapy in my office since:** ______ *DATE*
- **Patient has had a systemic reaction in before.** No Yes* ______ **LIST DATE AND DESCRIPTION*
- **Oral antihistamine required before injection.** No Yes
- **Patient required to carry their own epinephrine auto-injector on shot days in case of reaction after leaving the allergy clinic.** No Yes
- **Patient has asthma.** No Yes
- **Patient required to take maintenance asthma medication and/or inhaler to receive injections.** No Yes* ______ **LIST DRUGS AND INSTRUCTIONS*
- **Patient required to have Peak Flow measured before injection.** No Yes* ______ **LIST MINIMUM PEAK FLOW TO RECEIVE INJECTIONS* ______ **LIST PATIENT'S PERSONAL BEST PF*
- **Patient permitted to have flu vaccine at same visit as allergy injections.** No Yes
- **Medications patient is taking, dosage, and frequency:** ______ **PLEASE ATTACH MEDICATION LIST IF NECESSARY*
- **Other pertinent diagnosis:** ______

☐ **I request that UHS 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 ONLY: ______

UHS NURSE SIGNATURE // DATE