



Student Health and Wellness Center

Dear Allergy Provider,

Your patient has requested to continue their allergy injections at the Student Health Center while attending the University of Wisconsin-Milwaukee. The Nursing staff are happy to assist your patient in continuing the allergy injection regime you have ordered and would like your help in doing so. Due to the number of different allergists offices we work with, we are asking you or your office representative to complete the attached UW-Milwaukee Student Health and Wellness Annual Allergy Intake Form indicating how you would like us to handle a variety of scenarios we have encountered working with multiple allergy patients. We are asking for this form to be reviewed and updated annually.

In addition, we ask that the allergy serum vial (s) be clearly labeled with the following: *Patient Name, Date of Birth, Content(s), Dilution Concentration, and Expiration Date.*

Vials are accepted by drop off or mail Monday-Friday, 9am-4:30pm, unless closed for a holiday. Contact us at 414-229-7429 in advance to ensure the Student Health and Wellness Center will be open to alert our office of their pending arrival. All shipped packages should be labeled "REFRIGERATION REQUIRED" and addressed as follows: *Student Health and Wellness Center at 2025 E Newport Avenue Building D 7th floor, Milwaukee, WI 53211 with Attention: Allergy Nurse*

Thank You,

Student Health and Wellness Nursing Staff



Student Health and Wellness Center

2025 E Newport Avenue, Building D, 7th floor
P) 414-229-7429
F) 414-229-4161

Name: _____
 Birthdate: _____
 Allergist: _____
 Office phone: (____) _____
 Office fax: (____) _____
 Office hours: _____
 Office contact: _____

Annual Allergy Intake Form

Allergy History

Diagnosis _____
 Allergy injections started _____
 Build up? Y/N, if yes, has the patient received 5 or more doses at your office? Y/N
 Maintenance dose achieved? Y/N, if yes, date reached _____
 History of systemic reaction? Y/N, if yes, explain _____
 History of severe local reaction? Y/N if yes, explain _____
 History of asthma? Y/N Other chronic health issues? _____
Date of last dose given in allergy office: _____ **Reaction?** _____

Orders:

- Epipen: Is patient required to keep epipen with them on day of their injection? Y/N
- Peak flows required? Y/N, if yes, please indicate peak flow measurements needed to proceed with injection

- Premedication: NOT REQUIRED RECOMMEND REQUIRED (circle one please)
If required, how long in advance of injection should antihistamine be taken?

Preference for antihistamine? _____
- There are times when a student may come back to your office for their injections due to breaks, appointments, or other circumstances.
Can vials be sent out with patient? Y/N
Can vials be shipped overnight without ice? Y/N
If yes, please indicate shipping address _____
Any special instructions? _____
- Ordering NEW extract:
 - 2-3 weeks before vials run out _____
 - After dose # _____
 - Other, specify _____

Is patient signature required to order new vials? Y/N ****if yes, please provider form****

Please provide injection record with serum(s). Extracts should be clearly marked to correspond with orders. Contents of each vial need to be specified.

Extract Information

Vial content/dilution Expiration date	Vial content/dilution Expiration date	Vial content/dilution Expiration date	Vial content/dilution Expiration date
_____	_____	_____	_____
_____	_____	_____	_____

Dosing Orders-*complete below or include with injection record*

Dose Schedule and Frequency (if building)	OR	Maintenance Dose
_____ ml every _____ x _____		_____ ml every _____ weeks
_____ ml every _____ x _____		
_____ ml every _____ x _____		
_____ ml every _____ x _____		****NEW maintenance vials orders:
_____ ml every _____ x _____		_____
_____ ml every _____ x _____		_____
_____ ml every _____ x _____		_____
Minimum days between shots _____		

Late Injections: In considering students school/work schedules, we strive to keep students on a consistent shot schedule. However, we recognize that sometimes students are unable to keep appointments due to illness, school breaks, travel, negligence, or other circumstances. We will not give shots if students are febrile, wheezing, or have a respiratory infection. To expedite the patients care would you please provide instructions on how we should proceed in any of the above mentioned circumstances?

Days since last dose _____	Action _____
Days since last dose _____	Action _____
Days since last dose _____	Action _____
Days since last dose _____	Action _____
<i>Or other late dose instructions:</i> _____	

LOCAL REACTION ADJUSTMENT

At next visit: Repeat dose if swelling is > _____ mm and < _____ mm
Reduce by one dose increment if swelling is > _____ mm
Other orders _____

Physician Signature _____ Date _____