Carnegie Mellon University
University Health Services

Thank you for your interest in receiving allergy injections at our office while attending Carnegie Mellon University.

Your ability to receive your injections at our health center requires you to obtain information from your prescribing allergist. The information we need is included with this letter and is titled, **"Information from the Prescribing Allergist"**. We encourage you to contact your allergist as soon as possible to request they provide the necessary information to us. WE DO NOT ACCEPT PATIENTS WHO NEED MORE THAN **THREE** INJECTIONS OR THE FREQUENCY IS MORE THAN **WEEKLY**.

We ask you to abide by certain guidelines for receiving allergy injections in our office. These guidelines include the following:

Information from your Allergist. You are responsible for assuring that your prescribing allergist provides the information we need in a timely manner. We are available to answer questions they may have in completing the documentation.

First appointment. Upon receipt and review of information from your prescribing allergist, we will contact you to schedule your first appointment with one of our providers. Please note: The appointment will **not** be scheduled until we have received the information from your allergist.

Injection visits. Injections are administered on a scheduled basis. You may receive your injections during days and times when your prescribing allergist's office is open. This is necessary in the event we need to contact your allergist about your injections or reactions you may have experienced. We will not administer injections to you during days and times when your allergist's office is closed. You will need to sign the Allergy Injection Consent.

Your injection schedule. Your prescribing allergist will determine your treatment schedule and frequency of your allergy injections. It is your responsibility to maintain that schedule, so you do not fall behind in treatment. If you arrive for an injection and have fallen behind in treatment necessitating that we contact your allergist for dosing instructions, you will not receive your injection that day. After we have received instructions from your allergist, we will contact you to receive your injection. *Due to the importance of receiving injections on a regular basis and the disruption caused when falling behind in treatment, patients who do so more than twice in the year will not be able to receive their injections in our office.*

After injection wait time. Following your injection, we require that you wait 30 minutes in our office. This allows us to monitor you for reaction that may occur following the injection. If you fail to wait the required 30 minutes, we will discontinue your treatment.

Annual Wellness visits. Prior to receiving your first injection at our office, you will need to be seen by one of our providers to establish yourself as a patient. The provider will obtain your medical history and perform a brief examination. Each year thereafter you will need a wellness visit at our office to update your medical history. This is necessary so that we have current medical information in the event we need to treat you for a reaction to your injections or for allergies while you are in the area.

At the end of your time with us you are responsible for picking up your vials and returning them to your prescribing allergist.

If you have questions, please contact our office at 412-268-2157, option 2. We will be pleased to assist you.

Important information for your Allergist. Please enter your name and birthdate and provide these documents to your allergist.

Dear Doctor:

Your patient _____ DOB _____, has requested to receive allergy
(insert your name) (insert you date of birth)
injections in our office using treatment vials provided by your office.

Please note there are certain considerations for patients requesting to receive their injections in our office, which we have outlined below.

- Patient vial labels must be typewritten and contain an expiration date. Handwritten labels and “cross outs” are not acceptable.
- Injection records must be legible and contain unequivocal dosing instructions. These instructions must include directions for increasing patients through to their maintenance dose (interval and dose amount) and instructions for dose reductions if the patient is “late” for their injection or provided new vials
- The patient will be permitted to receive injections only during the operating hours of your office. This permits us to contact you if needed for consultation.

Please complete the **Information from the Prescribing Allergist** form and return it to us as soon as possible to allow time for review and follow up with your office if necessary. If you have questions regarding this request, please contact us at 412-268-2157, option 2.

Sincerely,

Carnegie Mellon University Health Services

Carnegie Mellon University Health Services
1060 Morewood Avenue
Pittsburgh, PA 15213
412-268-2157, option 2
Fax: 412-268-6357

Information from the Prescribing Allergist

Patient Name_____Date of Birth_____

Physician: _____Office Phone: _____Fax: _____

Office Address: _____

Days and hours your office is open_____

Contact person/phone # for questions_____

PLEASE FAX THE FOLLOWING RECORDS:

-Most recent office visit note (must have occurred in past 12 months)
-Injection record including most recent injection
-Dosing protocol for each vial/injection

VIAL FORMULA
(WE ARE LIMITED TO MAXIMUM OF 3 VIALS)

	NAME of extract vial	Vial Contents	Concentration for each Allergen	Extract Manufacturer	Diluent In ml	Total Volume In Vial	Expiration Date of Vial
1)							
2)							
3)							

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Systemic history _____Yes_____No
Injection Progress _____In Build-up _____At maintenance
Antihistamine required before injection _____YES _____NO
Personal Epinephrine Pen recommended ____YES _____NO

PLEASE COMPLETE TABLE BELOW:

REDUCTION PROTOCOL FOR MISSED INJECTION

During Build-Up Phase	After Reaching Maintenance
_____to_____days-continue as scheduled	_____to_____days-give same maintenance dose
_____to_____days-repeat previous dose	_____to_____weeks-reduce previous dose by_____ml
_____to_____days-reduce previous dose by____ml	_____to_____weeks-reduce previous dose by_____ml
_____to_____days-reduce previous dose by____ml	Over_____weeks-contact office for instructions
Over_____days-contact office for instructions	

REDUCTION PROTOCOL FOR REACTIONS:

At next visit: Repeat dose if swelling is >_____mm and <_____mm.
Reduce by one dose increment if swelling is >_____mm.

Other instructions:

_____

_____

Physician Signature: _____ Date: _____

PLEASE RETURN THIS FORM WITH REQUIRED DOCUMENTS BY FAX 412-268-6357

CLA 9/23
Rev 1/24 cla