

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 any 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 your 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 **Allergy Injection 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  
100 Tech Street, 3<sup>rd</sup> Floor  
Pittsburgh, PA 15213  
412-268-2157, option 2  
Fax: 412-268-6357

**Allergy Injection Information from the Prescribing Allergist**

Pt Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Physician: \_\_\_\_\_ Office Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Office Address: \_\_\_\_\_

Days & Hours 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 Allergan	Diluent in ml	Total Volume in Vial	Expiration Date of Vial
1						
2						
3						

**PLEASE ANSWER THE FOLLOWING QUESTIONS**

Systemic History: Y N

Injection Progress: \_\_\_\_ In Build Up \_\_\_\_ At Maintenance

Frequency of Injections: \_\_\_\_\_

Premedication w/ Antihistamine Required: Y N

Personal EpiPen Required: Y N

Rotate Doses/Arms: Y N

Health Screening Questions Prior to Allergy Injections? Y N

If so, list screening questions:

1.) \_\_\_\_\_

2.) \_\_\_\_\_

3.) \_\_\_\_\_

Patient Name: \_\_\_\_\_

**PLEASE COMPLETE THE TABLE BELOW: (FROM DATE OF LAST INJECTION)**

During Build Up Phase	During Maintenance Phase
___ to ___ days – continue as scheduled	___ to ___ days – give same maintenance dose
___ to ___ days – repeat previous dose	___ to ___ weeks – reduce previous dose by ___
___ to ___ days reduce previous dose by ____	___ to ___ weeks – reduce previous dose by ___
___ to ___ days – reduce previous dose by ____	Over ___ weeks – contact office for instructions
Over ___ days – contact office for instructions	

**Reduction Protocol for Local Reactions:**

At next visit:

repeat dose if swelling is greater than \_\_\_\_\_ mm and less than \_\_\_\_\_ mm.

reduce by one dose increment if swelling is greater than \_\_\_\_\_mm.

**Management of Systemic Reactions:**

Give \_\_\_cc’s of 1:1000 Epinephrine IM for following symptoms:

\_\_\_\_\_.

If not improved in \_\_\_\_\_ minutes: \_\_\_\_\_

If reaction is questionable/extremely mild: \_\_\_\_\_

**Ordering Vials:**

Reordering turnaround time required: \_\_\_\_\_

Allergist Signature: \_\_\_\_\_

<p>CMU Office Use Only:</p> <p>Emergency Contact: _____</p> <p>Vial Expiration: _____</p> <p>Date of Latest Allergy Physical: ____/____/____ (annual)</p> <p>Date Allergy Consent Signed: ____/____/____ (one time)</p>
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