UNIVERSITY HEALTH SERVICES
Tang Center

University of California, Berkeley
2222 Bancroft Way
Berkeley, CA 94720

Request for Allergy Immunotherapy Treatment Plan

The following information must be provided before allergy injections can be given at the UC Berkeley University Health Services Allergy/ Travel Clinic for your patient.

**All pages/attachments must be signed and dated by ordering clinician*

Patient's Name: _____ DOB: _____
Diagnosis: _____
History of Asthma? No Yes (describe on reverse): Peak Flows Needed? Yes No
Prescribed Medications: _____
Pre-Tx Needed? Yes No Med:
Known Drug or Food Allergies: _____
Original Immunotherapy Start Date: _____
History (Including systemic or other serious reactions):_____

Recommended direction at Tang Center (please BUILDING **OR** MAINTANENCE)

Building Up: Interval every _____weeks/days follow increase schedule:

Maintenance: Dose ____ML at an interval of every _____weeks/days.

Missing doses instruction and Immunotherapy schedule-**REQUIRED** IN ADDITION TO ABOVE **(MD needs to sign and date any attachments)**

_____
_____
_____
_____

****Please remember to attach a detailed immunotherapy orders and administration schedule that is signed and dated by the ordering clinician.**

For questions refer to: *https://uhs.berkeley.edu/medical/immunizations/information-patients-currently-receiving-allergy-shots*

Last dose of antigen given:

Date	Contents of Vial	Exp date of Vial	Vial Dilution	Dose Give (in mL)

Physician Name:_____
Office Address:_____
Office Hours:_____ Office Contact Person:_____
Phone #:_____ Fax #:_____
Physician Signature:_____ Date:_____

Please return forms by fax (510) 643-9790 or mail mail to University Health Services - Allergy/ Travel Clinic, 2222 Bancroft Way, Berkeley, CA, 94720-4300.