UNIVERSITY HEALTH SERVICES

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

UHS IMMUNOTHERAPY HISTORY AND STANDARDIZED MAINTENANCE ORDERS (4/19)

Patient Name:_____**DOB:**_____

Diagnosis_____

Known Environmental, Food or Drug Allergies_____

History (Immunotherapy start date, systemic and/or serious reactions)_____
Please attach additional history or medical records as necessary.

Immunotherapy to be administered:

Name of vial (ex. TGW)	**Dilution** (scientific nomenclature)	**Contents Of Vial** (ex. grass, weeds, trees)	**Expiration Of Vial**	**Maintenance Dose** (in mL)	**Injection Frequency** (days)	**Date of Last Dose**	**Last Dose Given** (in mL)

Prescribed Medication(s)_____

Pretreatment needed: ☐ **Yes** ☐ **No Medication**_____**Time**_____

Epinephrine device prescribed: ☐ **Yes** ☐ **No** (UHS strongly recommends an Epinephrine device while on IT)

History of Asthma: ☐ **Yes** ☐ **No** **Peak flow baseline**_____.
Peak flow required for any patient with history of asthma. If PF less than _____ (80% of baseline), Immunotherapy will not be given.

Maintenance Phase:
Dose Adjustments/drop for time lapse in injection schedule
2-4 weeks (15-28 days) since last injection: Decrease by_____**ml** OR ☐ Repeat dose
4-5 weeks (29-35 days) **since last injection**: Decrease by _____mL OR ☐ Repeat dose
5-6 weeks (36-42 days) **since last injection**: Decrease by _____mL OR ☐ Repeat dose
6 + weeks (43-49 days) **since last injection**: Decrease by _____mL

(If > 49 days since last injection UHS will contact allergist for dosing instructions. Student may need to establish care with local allergist for build-up).

Build up for time lapse and fresh antigen (UHS protocol for fresh antigen is to reduce by 50%)

Increase dose by _____mL every _____days until maintenance is reached.
(Missed dose/fresh antigen schedule from allergist's office may be accepted after UHS RN review. All schedules sent from allergist's offices are considered orders and must include patient's name, date of birth and **must be signed and dated by clinician.**)

Clinician Name_____**Phone**_____

Office Address_____**Fax**_____

Office Hours_____**Contact Person**_____ **Email**_____

Clinician Signature_____**Date**_____