# Penn State Behrend Health and Wellness Center

# Academic Year 2024-2025 Referring Allergist Agreement

Students requesting allergy immunotherapy administration at Penn State Behrend Health and Wellness Center (HWC) are required to have their referring allergist complete this form.

**Note: Penn State University Behrend Health and Wellness Center will not complete or sign any type of form from referring allergist’s office.**

**Deadline**: Referring Allergist Agreement form must be completed and received in the Allergy Clinic prior to scheduling the first appointment. **This order will expire June 30, 2025,** and new forms must be provided to continue immunotherapy.

## Allergist Agreement

My patient (printed name): Date of Birth: ,

requests that Penn State Behrend Health and Wellness Center administer allergy extracts provided by my office.

### Allergist Information:

Name:

Office Phone Number:

Office Fax Number:

Office Hours:

### Patient Information:

Patient has been receiving immunotherapy in my office since:

*Select the appropriate checkbox below. Provide additional details if requested.*

1. Has patient had a systemic reaction: [ ]  Yes [ ]  No

If yes, provide date(s)/description:

1. Is an oral antihistamine required before injections on
injection days? [ ]  Yes [ ]  No

If yes, provide **minimum hours / minutes** before injections:

1. Is patient required to carry their own EpiPen on injection
days in case of reaction after they leave the allergy clinic? [ ]  Yes [ ]  No
2. I have prescribed the EpiPen: [ ]  Yes [ ]  No

My office has instructed the student on its usage: [ ]  Yes [ ]  No

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1. Does patient have asthma? [ ]  Yes [ ]  No

Is asthma currently well controlled? [ ]  Yes [ ]  No
[ ]  Not Applicable

1. Is patient required to have Peak Flow measured before injections? [ ]  Yes [ ]  No

If required, what is the minimum Peak Flow to receive injection(s)?

Medications patient is taking including dosage and frequency (attach medication list if necessary):

Other pertinent diagnoses:

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**I agree that:**

* I will provide allergen immunotherapy extracts in adequately labeled vials (including vial contents and concentration) for administration at Penn State University HealthServices.
* I will provide detailed instructions regarding dosage schedule for buildup phase and/or maintenance, late or missed injections, local reactions, and signed, faxed instructions on adjustments that might be necessary.
* I will continue to be responsible for the management of this patient’s immunotherapy and for the modification of doses during therapy.
* Allergy injections are associated with some widely recognized risks. While most adverse reactions are local, there is a risk of severe systemic reactions even with appropriately administered allergen immunotherapy; life-threatening and fatal reactions do occur. In the event a patient presents with a systemic reaction, I understand the following emergency measures will be taken, as indicated:
	+ Epinephrine 0.3ml 1:1000 IM (may use Adult or Junior EpiPen as indicated)-can repeat at 5 to 15-minute intervals
	+ Benadryl 50 mg IM
	+ Oxygen via nasal cannula at 6-8 L/min
	+ BP, pulse, respirations, and O2 Sat every 5 minutes
	+ Nebulizer treatment with Albuterol 0.083%, if indicated
	+ Solu-Medrol 125mg IV push over 1 minute, if indicated
	+ 911 called if Epinephrine is given

**Referring Allergist Signature**: **Date**:

**Referring Allergist Printed Name**:

**After completing, signing, and dating this form, please fax form to: ATTN: Allergy Nurse 814-898-6924**