

**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 allergists 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: _____

Patient **has / has not** had a systemic reaction. Date(s)/description: _____

Oral antihistamine **is / is not** required _____ (minimum **hours / minutes**) before injections on injection days.

Patient **is / is not** required to carry their own EpiPen on injection days in case of reaction after they leave the allergy clinic.

I have prescribed the EpiPen (**yes / no**). My office has instructed the student on its usage (**yes / no**).

Patient **does / does not** have asthma. Is asthma currently well controlled? (**yes / no / not applicable**)

Patient **is / is not** required to have Peak Flow measured before injections. If required, what is minimum Peak Flow to receive injection(s)? _____

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

Other pertinent diagnoses:

**Penn State Behrend Health and Wellness Center
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Patient Name _____ **Date of Birth** _____

I Agree that:

- I will provide allergen immunotherapy extracts in adequately labeled vials (including vial contents and concentration) for administration at Penn State University Health Services.
- 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