ADMINISTRATION/ORDER FOR ALLERGEN IMMUNOTHERAPY FORM

Patient Information		Allergist/Practice Information	
Last Name	First	Name of Allergist	
Date of Birth	OSU ID #	Address	
Diagnosis		Telephone	Fax
History (include previous reactions)		Allergist Signature	
Date & Amount of Last Injection		Fax completed form to 614-292-7042	

Vial Information					
Vial ID					
Content					
Dilution					
Expiration date					
Frequency of injections					
Arm (if designated)					
Injection #	Prescribed Dose	Prescribed Dose	Prescribed Dose	Prescribed Dose	Prescribed Dose
1	0.___ml	0.___ml	0.___ml	0.___ml	0.___ml
2	0.___ml	0.___ml	0.___ml	0.___ml	0.___ml
3	0.___ml	0.___ml	0.___ml	0.___ml	0.___ml
4	0.___ml	0.___ml	0.___ml	0.___ml	0.___ml
5	0.___ml	0.___ml	0.___ml	0.___ml	0.___ml
6	0.___ml	0.___ml	0.___ml	0.___ml	0.___ml
7	0.___ml	0.___ml	0.___ml	0.___ml	0.___ml
8	0.___ml	0.___ml	0.___ml	0.___ml	0.___ml
9	0.___ml	0.___ml	0.___ml	0.___ml	0.___ml
10	0.___ml	0.___ml	0.___ml	0.___ml	0.___ml

Pre/post injection instructions (may be attached as separate document):

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