THE OHIO STATE UNIVERSITY
OFFICE OF STUDENT LIFE

Student Health Services
1875 Millikin Road
Columbus, OH 43210
Phone 614-292-4321
Fax 614-292-7042

# INSTRUCTIONS FOR PATIENTS

Welcome to Student Life Student Health Services (SLSHS) and thank you for expressing interest in continuing your Allergy Immunotherapy Injection Treatment in our clinic. First, we want you to be aware that you are welcome to seek care at Student Health Services for allergy-related concerns, even if you have not yet established regular allergy injection appointments with us. Our providers and nurses can:

- Assess suspected reactions or complications related to allergy treatment
- Evaluate and treat allergy symptoms (e.g., nasal congestion, hives, shortness of breath)
- Evaluate complications or worsening of allergy symptoms
- Provide treatment or symptom relief
- Carry out allergy injections once prescribed by your allergist

There is a high demand for students requesting to continue allergy therapy at Student Health Services. Please contact our office to confirm that we are accepting new patients for allergy therapy injections before proceeding (614-292-4321).

Allergen Immunotherapy is administered at Student Health Services in accordance with the written and signed orders from your allergist. Our ability to effectively and safely administer allergy injections depends on the completeness, accuracy, and on-time information from you and your allergist.

## BEFORE YOU CAN SCHEDULE AN ALLERGY INJECTION APPOINTMENT

### Requirements for the Patient

- ❑ Call to confirm we are accepting new allergy injection patients (614-292-4321).
- ❑ Login to My BuckMD (secure patient portal) https://shs.osu.edu/my-buckmd1 to verify you can access “Messages” from our clinic.
- ❑ Coordinate with your allergist on WHEN and HOW orders and vials will be prepared and delivered to the Student Health Services Pharmacy.

### Requirement for the Referring Allergist

- ❑ See INSTRUCTIONS FOR REFERRING ALLERGISTS
- ❑ All required forms and attachments should be faxed to our clinic.
- ❑ Vials should be delivered (or sent with patient) to our Pharmacy with **all documents included**.

  Student Health Services Pharmacy
  Attention: Allergy Injection Nurse
  1875 Millikin Road
  Columbus, OH 43210
  Phone 614-292-4321 / Fax 614-292-7042

**Patients will not be able to schedule until all paperwork and vials have been received and verified.**

**Student Health Services will follow these steps for all patients accepted to start allergy injections in our clinic.**

- ❑ Send “Welcome to Allergy Injection Therapy” message in My BuckMD to accepted patients.
- ❑ Wait for documents and vials to be delivered by the allergist or patient to our Pharmacy.
- ❑ Verify completeness of forms when received.
- ❑ Verify vials are adequately labeled when received.
- ❑ Send “You are eligible to schedule Allergy Injection Appointments” message to patient in My BuckMD.

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## AFTER ALL REQUIRED FORMS AND VIALS HAVE BEEN RECEIVED

If you are waiting for the "You are eligible to schedule Allergy Injection Appointments" message in My BuckMD, call your allergist to confirm they have completed all requirements and have sent complete paperwork and vials to our pharmacy.

### Patient Responsibilities

- ❑ If you received a message in My BuckMD that "You are eligible to schedule Allergy Injection Appointments", call to schedule your first injection with us (614-292-4321).
- ❑ Review ALLERGY INJECTION CONSENT FORM, in My BuckMD, signature is required before we can administer injections (can sign at first appointment).
- ❑ Have your health insurance information available for your first appointment. Contact your health insurance company if you have questions about coverage.

### Referring Allergist Responsibilities

- ❑ Be responsive to requests for information, documentation, or status updates from patients and Student Health Services.

## ONGOING ALLERGY THERAPY

### Patient Responsibilities

**Schedule Ahead**

- ❑ Refer to your prescribed injection schedule and schedule ahead.
- ❑ Patients can call our appointments line to schedule (614-292-4321) or schedule online in My BuckMD.

  Online scheduling is only available to patients that have been accepted.

**Allergy Vial Pickup and Transfer**

If you need to take your allergy vials back to your allergist at any time (i.e. Winter Break, Spring Break), please follow these steps:

- Contact the allergy nurse by sending a secure message in My BuckMD or call the appointments line (614-292-4321).
- We require a **three (3) business day notice** to prepare your vials and paperwork for pickup.

You will receive a secure message in My BuckMD when your vials are ready to pick up in our Pharmacy.

### Referring Allergist Responsibilities

**Promptly Update Orders and Vials as needed**

- ❑ Updated orders/instructions should be faxed to 614-292-7042 ATTN: Allergy Nurse
- ❑ Mail paperwork with vials to:

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# INSTRUCTIONS FOR REFERRING ALLERGIST

At Student Health Services, our top priority is delivering care in the safest and most effective way possible. Each academic year, we administer allergy injections to over 150 students referred by more than 80 certified allergy specialists. To ensure patient safety, we require all referring allergists to complete specific Student Health Services forms before we can begin administering injections. Students are welcome to schedule appointments at any time for symptomatic treatment, even if injection requirements are still pending. Our nursing staff operates under standing orders to respond to any adverse reactions. In the event of an emergency, our on-site medical providers are fully equipped to deliver immediate and appropriate care.

Allergen Immunotherapy is administered at Student Health Services in accordance with the written and signed orders of the patient's prescribing allergist. Follow these instructions to get your patient established in our clinic.

- ❑ Agree to the standards documented in the **REFERRING ALLERGIST AGREEMENT** (attached)
- ❑ Provide signed orders using the **ALLERGEN IMMUNOTHERAPY ORDER FORM** (attached)
- ❑ **Attach other documents required for treatment**, including but not limited to
  - Current shot record or treatment history
  - Detailed directions regarding dosage/schedule adjustments for missed scheduled injections
  - Detailed instructions for local or systemic reactions
- ❑ **Fax** completed forms and attachments to **614-292-7042 Attn: Allergy Injection Nurse**
- ❑ **Send vials** with paperwork to our pharmacy (or send them with the patient). Include the required forms and attachments. Vials and paperwork should arrive together.

Student Health Services Pharmacy
Attention: Allergy Injection Nurse
1875 Millikin Road
Columbus, OH 43210
Phone 614-292-4321 / Fax 614-292-7042

*We will not proceed with scheduling the patient for allergy injections until satisfactory documentation is received and can be matched to the adequately labeled vials.*

Fill-In Forms and instructions are also available at https://shs.osu.edu/services/allergy-therapy

To avoid additional burden for the patient and unnecessary disruptions in treatment, follow all instructions outlined above and contact us promptly with any questions. We appreciate your cooperation and collaboration as we work together to treat our patients.

Sincerely,

Student Health Services Providers and Staff

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# REFERRING ALLERGIST AGREEMENT

My patient (listed below) is requesting The Ohio State University Office of Student Life, Student Health Services (SLSHS) administer allergy extracts provided by my office.

Patient Full Name _____

Date of Birth _____

**I agree to the following:**

- I will provide allergen immunotherapy extract in adequately labeled vials for administration at SLSHS. Adequately labeled vials will include **patient first and last name, date of birth, content of vial, dilution, and expiration date.**
- I will provide detailed directions regarding the dosage schedule for buildup phase and/or maintenance by completing the **ALLERGEN IMMUNOTHERAPY ORDER FORM** provided by SLSHS.
- I will provide detailed directions regarding dosage/schedule adjustments that might be necessary due to patient missing scheduled injections by completing the **ALLERGEN IMMUNOTHERAPY ORDER FORM** provided by SLSHS.
- I will provide detailed directions for local or systemic reactions by completing the **ALLERGEN IMMUNOTHERAPY ORDER FORM** provided by SLSHS.
- I will continue to be responsible for the management of this patient's immunotherapy and for the modification of doses during therapy.
- I will be available by phone to the SLSHS health care team if questions or problems arise with the patient's immunotherapy.
- I understand that SLSHS encourages all patients to have an EpiPen with them when they receive their allergy injections.
- I am aware that **patients** can request their vials be released to them as needed for injections if they plan to leave campus or are otherwise away from our clinic, and that SLSHS instructs patients that a minimum **3 business-day notification** is required for pickup in the pharmacy.
- I understand that expired vials will be discarded on the date of expiration.

Allergist Signature _____ Date _____

Allergist Printed Name _____

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# ALLERGEN IMMUNOTHERAPY ORDER FORM

**Fax completed forms to 614-292-7042 Attn: Allergy Injection Nurse. All information is required.**

**Patient Information**

Last Name _____

First Name _____

Date of Birth _____

Diagnosis _____

Required to medicate prior to injection? _____No ____Yes (specify)

_____

Last Injection Dose 0._____mL

Last Injection Date _____

**Practice/Office Information**

Office _____

Address _____

_____

Phone _____Secure Fax _____

Allergist Signature

Printed Name _____

Date Allergist Signed _____

Allergy History, including previous reactions (check here if attached as separate document ☐)

Instructions for missed scheduled injections
(check here if attached as separate document ☐)

Instructions for local or systemic reactions
(check here if attached as separate document ☐)

| Vial Information | | | | | | |
|---|---|---|---|---|---|---|
| **Vial ID** | | | | | | |
| **Content** | | | | | | |
| **Dilution** | | | | | | |
| **Exp Date** | | | | | | |
| **Frequency** | | | | | | |
| **Arm (L/R)** | | | | | | |
| **Injection #** | **Prescribed Dose** | **Prescribed Dose** | **Prescribed Dose** | **Prescribed Dose** | **Prescribed Dose** | **Prescribed Dose** |
| **1** | 0._____mL | 0._____mL | 0._____mL | 0._____mL | 0._____mL | 0._____mL |
| **2** | 0._____mL | 0._____mL | 0._____mL | 0._____mL | 0._____mL | 0._____mL |
| **3** | 0._____mL | 0._____mL | 0._____mL | 0._____mL | 0._____mL | 0._____mL |
| **4** | 0._____mL | 0._____mL | 0._____mL | 0._____mL | 0._____mL | 0._____mL |
| **5** | 0._____mL | 0._____mL | 0._____mL | 0._____mL | 0._____mL | 0._____mL |
| **6** | 0._____mL | 0._____mL | 0._____mL | 0._____mL | 0._____mL | 0._____mL |
| **7** | 0._____mL | 0._____mL | 0._____mL | 0._____mL | 0._____mL | 0._____mL |
| **8** | 0._____mL | 0._____mL | 0._____mL | 0._____mL | 0._____mL | 0._____mL |
| **9** | 0._____mL | 0._____mL | 0._____mL | 0._____mL | 0._____mL | 0._____mL |
| **10** | 0._____mL | 0._____mL | 0._____mL | 0._____mL | 0._____mL | 0._____mL |

ALLERGEN IMMUNOTHERAPY ORDER FORM