Instructions for the Referring Allergist:

- Complete and sign Referral Agreement Form
- Complete and sign Administration/Order Form
- Complete and sign Administration Information Form
- Fax completed forms to 614-292-7042

REFERRAL AGREEMENT FOR ALLERGEN IMMUNOTHERAPY FORM

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

Patient Name _____

Date of Birth _____

I agree to the following:

- I will provide allergen immunotherapy extract in adequately labeled* vials for administration at SLSHS.
  Patient first and last name, date of birth, content of vial, dilution, expiration date
- I will provide detailed directions regarding dosage schedule for buildup phase and/or maintenance by completing the **Administration/Order Form** provided by SLSHS.
- I will provide detailed directions regarding dosage/schedule adjustments that might be necessary due to patient missing scheduled injections or due to local or systemic reactions by completing the **Administration/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 this patient's immunotherapy.
- I understand that SLSHS encourages **all** patients to have an EpiPen with them when they receive their allergy injections.

Allergist Signature _____ Date _____

Allergist Printed Name _____

REFERRAL AGREEMENT FOR ALLERGEN IMMUNOTHERAPY FORM