



ALLERGEN IMMUNOTHERAPY ADMINISTRATION/ORDER 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		

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):