Letter to Allergist

Swarthmore College Student Health Center
500 College Avenue
Swarthmore, PA 19081
610-328-8058

The Swarthmore College Student Health Center's goal is to provide care needed by our student patients in the safest way possible. Your assistance with this goal is not only required but also greatly appreciated.

Our allergy clinic serves dozens of student patients referred by multiple different allergy specialists. Each allergy specialist has a unique form they use in their office. As you can imagine, navigating multiple forms is very challenging and has significant potential for error. Therefore, to maximize the safety margin for the student patients, our clinic has developed an Allergen Immunotherapy Administration form that we will utilize for every student patient in our allergy clinic.

In order for student patients to receive allergy immunotherapy at the Swarthmore College Student Health Center, we **require** the following:

1) Every student patient's initial injection(s) must be performed at the allergist's office.
2) We will not mix or dilute any extracts; this must be done by the prescribing allergist. We will store extracts in the Student Health Center medical refrigerator that has a backup generator.
3) Each vial must be clearly labeled with:
    a) Patient's name and date of birth
    b) Name of the antigen(s)
    c) Dilution
    d) Expiration date
4) The Allergen Immunotherapy Administration form MUST be completed and provided to the Student Health Center prior to a student patient receiving injections.
5) At the bottom of the Allergen Immunotherapy Administration form, the referring allergist must sign that they understand the student patient will receive allergy immunotherapy injections during operational hours at the Student Health Center when a physician and/or nurse practitioner trained in emergency anaphylaxis response is on site.

These requirements are purely for the safety of our student patients. Failure to complete these steps could delay and potentially prevent utilization of our services.

Sincerely,

Casey Anderson, CRNP
Director, Student Health and Wellness
Swarthmore College
500 College Avenue
Swarthmore, PA 19081

Allergen Immunotherapy Administration form

Swarthmore College Student Health Center
Ph: 610-328-8058 Fax: 610-690-5724

For your patient's safety and to facilitate the transfer of allergy treatment to our clinic, this form must be completed to provide standardization and prevent errors. Failure to complete this form in its entirety will delay or prevent the patient from utilizing our services. **This completed form along with a copy of the most recent shot record can be delivered by the patient, mailed, or faxed.**

Patient Name: _____ Date of birth: _____
Allergist: _____ Office phone: _____
Secure fax: _____ Office address: _____

PRE-INJECTION CHECKLIST:

- Is peak flow required prior to injection? NO YES If yes, peak flow must be ≥ _____L/min to give injection
- Is the student required to have taken an antihistamine prior to injection? NO YES
- Are the injections required to be placed in alternate sites? NO YES

INJECTION SCHEDULE:

Begin with _____ (dilution) at _____ ml (dose) and increase according to the schedule below.

Vial Contents							
Dilution							
Vial Cap Color							
Expiration Date(s)	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
	ml	ml	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml	ml	ml
	Go to next dilution	*Go to next dilution*	*Go to next dilution*	*Go to next dilution*	*Go to next dilution*	*Go to next dilution*	*Go to next dilution*

MANAGEMENT OF MISSED INJECTIONS: (According to the number of days from LAST injection)

During Build-Up Phase	***After Reaching Maintenance***
___ to ___ days – continue as scheduled	___ to ___ days – give same maintenance dose
___ to ___ days – repeat previous dose	___ to ___ weeks – reduce previous dose by _____ (ml)
___ to ___ days – reduce previous dose by _____ (ml)	___ to ___ weeks – reduce previous dose by _____ (ml)
___ to ___ days – reduce previous dose by _____ (ml)	Over ____ weeks – contact office for instructions
Over ____ days – contact office for instructions	

REACTIONS: *At next visit:* Repeat dose if swelling is > _____mm and < _____mm.

Reduce by one dose increment if swelling is >_____mm.

By signing this form you acknowledge that your student patient may receive allergy immunotherapy when a physician and/or nurse practitioner trained in emergency response and anaphylaxis management is on site.

Allergist signature: _____ Date: _____