Patient Name: Date of Birth: Patient Number: Telephone Number: Diagnosis:	Prescribing Physician: Address: **Telephone:** **Fax:**

Allergen Immunotherapy Administration Form

Dilution Color	1:10,000 (v/v) Silver	**1:1000 (v/v) Green**	**1:100 (v/v) Blue**	**1:10 (v/v) Yellow**	**Maintenance 1:1 (v/v) Red**
Vial number	5	**4**	**3**	**2**	**1**
Expiration date(s)	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____

Vaccine Name Abbreviations*	
Tree: T	Mold: M
Grass: G	Cat: C
Weed: W	Dog: D
Ragweed: R	Cockroach: Cr
Mixture: Mx	Dust Mite: Dm

____

Best Baseline Peak Flow: ____________________
Baseline Blood Pressure: ____________________

Vaccine A: ***vaccine contents**** | **Vaccine B:** | **Vaccine C:**______________

Date	Time	Health screen abnormal[1]	Anti-histamine taken?[2]	Peak Flow	Arm (A)	Vial Number or Dilution (A)	Delivered Volume (A)	Reaction[3] (A)	Arm (B)	Vial Number or Dilution (B)	Delivered Volume (B)	Reaction (B)	Arm (C)	Vial Number or Dilution (C)	Delivered Volume (C)	Reaction[3] (C)	Injector Initials
1. ___/___/___		Y N	Y N		R L				R L				R L				
2. ___/___/___		Y N	Y N		R L				R L				R L				
3. ___/___/___		Y N	Y N		R L				R L				R L				
4. ___/___/___		Y N	Y N		R L				R L				R L				
5. ___/___/___		Y N	Y N		R L				R L				R L				
6. ___/___/___		Y N	Y N		R L				R L				R L				
7. ___/___/___		Y N	Y N		R L				R L				R L			-	
8. ___/___/___		Y N	Y N		R L				R L				R L				
9. ___/___/___		Y N	Y N		R L				R L				R L				
10. ___/___/___		Y N	Y N		R L				R L				R L				
11. ___/___/___		Y N	Y N		R L				R L				R L				
12. ___/___/___		Y N	Y N		R L				R L				R L				
13. ___/___/___		Y N	Y N		R L				R L				R L				
14. ___/___/___		Y N	Y N		R L				R L				R L				
15. ___/___/___		Y N	Y N		R L				R L				R L				
16. ___/___/___		Y N	Y N		R L				R L				R L				

1. **Health screen** *refers to either a written or verbal interview of the patient prior to the administration of the allergy injection regarding: the presence of increased allergy or asthma symptoms or symptoms of respiratory tract infection, beta-blocker use, change in health status (including pregnancy) or adverse reaction to previous injection. A* ***yes*** *answer to this health screen may require further evaluation (see health screen record on back page).*
2. **Antihistamine use:** *to improve consistency in interpretation of reactions it should be noted if the patient has taken an antihistamine on injection days. Physician may also request that* ***antihistamines be taken consistently on injection days****:* ***recommended: Y N***
3. **Reaction**: *refers to either immediate or delayed systemic or local reactions. Local reactions (noted as LR) can be reported in millimeters as the longest diameter of wheal and erythema.. The details of the symptoms and treatment of a systemic reaction (noted as SR) would be recorded elsewhere in the medical record.*

Injector signature	Initials

Projected Build-up Schedule				
Vial 5	Vial 4	Vial 3	Vial 2	Vial 1

Date to reorder: __/__/__

Udated August 28, 2007