Allergen Immunotherapy Systemic Reaction/Anaphylaxis Treatment Record

Name:____ Date:______________

Date of Birth:__________________ Prescribing Physician:______________________________

Allergens: Tree-Grass-Weed-Mites-Cockroach-Animal Dander-Mold-Hymenoptera

Prior systemic rxn:__________ Hx of asthma?_____________

Date/time of injection:_________________ Date/time of rxn:____________________

Dilution (Vial #): ________________ New? Yes No

History of the systemic reaction (SR):

Immediate measures:
__Assess airway, breathing, circulation, and orientation
__Epinephrine IM into arm or when possible anterolateral thigh
__Activate EMS (call 911 or local rescue squad) Y/N Time called:______AM/PM
__Management algorithm reviewed (as needed)

Signs and Symptoms

Respiratory:
Shortness of Breath
Wheezing
Cough
Stridor

Skin:
Hives
Angioedema
Generalized Itch
Flushing

Eye/Nasal:
Runny Nose
Red Eyes
Congestion
Sneezing

Vascular:
Hypotension
Chest Discomfort
Dizziness

Other:
Difficulty Swallowing
Abdominal pain, nausea, diarrhea
Diaphoresis
Headache
Uterine cramps
Impending doom

Time	Resp. rate/ PEFR	Pulse/ O2 Saturation	BP	Intervention, Medications, Exam Comments

Time of discharge from the office:____________ Condition upon release: ____
Patient instructions:
____

Follow-up call to patient:
Time____
Comments:
____
____
____

WAO Subcutaneous Immunotherapy Systemic Reaction Grading System Final Report:
Grade a-d,or z ________________First symptom ________________ Time of onset of first symptom ________________
Dosage adjustment? ____

Signatures_________________________ RN__________________________ARNP/PA __________________________ MD/DO