Stamps Health Services
Allergy Injection Schedule Orders for Georgia Tech Patients

Please provide information about the allergy practice.

Name: _____ Allergist: _____ Phone # _____

Email: _____ Fax # _____ Pt Acct : _____

Please provide information about the patient to receive allergy injections at Stamps Health Services.

Patient name:_____ Date of Birth: _____ Cell phone #: _____

Vial #/Name		Vial #/Name		Vial #/Name		Vial #/Name	
Dilution		Dilution		Dilution		Dilution	
Color		Color		Color		Color	
Exp. Date		Exp. Date		Exp. Date		Exp. Date	

Proceed to next vial _____ See new schedule for next vials _____ All vials given on same schedule _____	Proceed to next vial _____ See new schedule for next vials _____ All vials given on same schedule _____	Proceed to next vial _____ See new schedule for next vials _____ All vials given on same schedule _____	Proceed to next vial _____ See new schedule for next vials _____ All Vials given on same schedule _____

Frequency of Injections: _____

_____

_____

Instructions for dose adjustments: _____

_____

_____

_____

_____

_____

Pre medicate ☐ Y ☐ N with: _____

Peak Flow ☐ Y ☐ N minimum _____

Alternate arms ☐ Y ☐ N At Maintenance ☐ Y ☐ N

Signature: _____ Date: _____