APPENDIX 11. Allergen immunotherapy administration form

Allergen Immunotherapy Administration Form

Patient Name: **Date of Birth:**
Patient Number:
Telephone Number: **Diagnosis:**

Prescribing Physician:
Address:

Telephone: **Fax:**

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)	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___

Immunotherapy	A	B
Date started		
Date maintenance dose reached		
Maintenance dose		
Maintenance interval		

Best Baseline Peak Flow: _____
Baseline Blood pressure: _____

Allergen extract: ***contents***

	Date	Time	Health screen abnormal[1]	Anti-histamine taken?[2] or premed	Peak Flow	Arm	Vial Number or Dilution	Delivered Volume	Reaction[3]	Injector Initials
1.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	_____
2.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	_____
3.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	_____
4.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	_____
5.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	_____
6.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	_____
7.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	_____
8.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	_____
9.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	_____
10.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	_____
11.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	_____
12.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	_____
13.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	_____
14.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	_____
15.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	_____
16.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	_____
17.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	_____
18.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	_____
19.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	_____
20.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	_____
21.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	_____
22.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	_____
23.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	_____
24.	___/___/___	_____	Y N	Y N	_____	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. Guidelines for dose reduction after a systemic reaction on a separate instruction sheet.*

Injector signature	Initials

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

Date to reorder: __/__/__

Allergen Immunotherapy Administration Form

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

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)	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___

Immunotherapy	**A**	**B**
Date started		
Date maintenance dose reached		
Maintenance dose		
Maintenance interval		

Best Baseline Peak Flow: _____
Baseline Blood pressure: _____

Allergen extract: ***contents***

Allergen extract B: _____

	Date	**Time**	**Health screen abnormal[1]**	**Anti-histamine taken?[2] or premed**	**Peak Flow**	**Arm**	**Vial Number or Dilution**	**Delivered Volume**	**Reaction[3]**	**Arm**	**Vial Number or Dilution**	**Delivered Volume**	**Reaction**	**Injector Initials**
1.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	R L	_____	_____	_____	_____
2.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	R L	_____	_____	_____	_____
3.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	R L	_____	_____	_____	_____
4.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	R L	_____	_____	_____	_____
5.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	R L	_____	_____	_____	_____
6.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	R L	_____	_____	_____	_____
7.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	R L	_____	_____	_____	_____
8.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	R L	_____	_____	_____	_____
9.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	R L	_____	_____	_____	_____
10.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	R L	_____	_____	_____	_____
11.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	R L	_____	_____	_____	_____
12.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	R L	_____	_____	_____	_____
13.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	R L	_____	_____	_____	_____
14.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	R L	_____	_____	_____	_____
15.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	R L	_____	_____	_____	_____
16.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	R L	_____	_____	_____	_____
17.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	R L	_____	_____	_____	_____
18.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	R L	_____	_____	_____	_____
19.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	R L	_____	_____	_____	_____
20.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	R L	_____	_____	_____	_____
21.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	R L	_____	_____	_____	_____
22.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	R L	_____	_____	_____	_____
23.	___/___/___	_____	Y N	Y N	_____	R L	_____	_____	_____	R L	_____	_____	_____	_____
24.	___/___/___	_____	Y N	Y N	_____	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).*

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Injector signature	**Initials**

Date to reorder: __/__/__

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