

Allergy Injection Program

University of Southern California

Dear Doctor,

Your patient is requesting transfer and continuation of his/her allergy desensitization injection program to the University of Southern California (USC), University Park Health Center, while he/she attends USC.

The program is managed under the supervision of our consulting allergists. Our goal is to maintain a hyposensitization program for students who have been in a continuing program through their private physician. Whenever possible, and in accordance with our policies, all students will be admitted and maintained in our program.

Our intent is to follow the prescribing physician's orders and schedule as completely as possible, to the extent that they fall within the guidelines of our program. These guidelines will take precedence if any aspect of the student's hyposensitization program is ambiguous or in conflict with our philosophy, procedures and policies.

In order to maintain this program, we ask that you take a few moments to provide the information requested on the following forms. A summary letter, containing similar information can be sent in lieu of this form. Please note that any missing information may lead to a delay in administration of the student's allergy injections.

Please note that all antigen vials must have the following information printed legibly on their labels, or they may be sent back for proper labeling:

1. Patient's name
2. Expiration (and preferably preparation) date (s)
3. Dilution or concentration (i.e., 1:1000 or 500 BAU, etc.)
4. Physician's name
5. Contents (i.e., tree mix, environmentals, etc.). A full list of exact contents is not necessary.

The Allergy Clinic Nurse fully reviews the student's records, allergy treatment and hyposensitization program. If the criteria are met, and appointment will be made for the student in the Allergy Clinic. At this time, the student will be evaluated by our Consulting Allergist and if all is in order, the injections will be started.

Thank you, in advance, for your cooperation.

Allergy Injection Program
Allergy History and Therapy Form

Patient's Name: _____

Patient's Social Security No.: _____ Date of Birth: _____

Diagnosis:

1. _____
2. _____
3. _____

Pertinent Test Results:

Medications Prescribed:

Known Drug or Food Allergies:

Other Essential Information:

Onset of therapy:

Month: _____ Year: _____ Date of last injection: _____/_____/_____

Vaccines: (In lieu of the below schedule, you may substitute with your "routine" send-out treatment schedule)

Vial Contents	Expiration Date	Start At	Advance By:		Maintain At:
			Dilution / Volume	Increment / Frequency	Maximum Dilution / Volume / Frequency

Has your patient exhibited local reactions on the present treatment program? No Yes

If yes, please describe: _____

Has your patient exhibited systemic reactions on the present treatment program? No Yes

If yes, please describe: _____

Any further pertinent information: _____

Physician's Name: (please print) _____

Signature: _____ Date: _____

Address: _____

Tele. #: (_____) _____