Ramapo College of New Jersey
Center for Health and Counseling Services
505 Ramapo Valley Road Mahwah, NJ 07430
Ph: 201-684-7536 Fax: 201-684-7534

ALLERGY CLINIC

Dear Allergy Provider,

Ramapo College of New Jersey Health Service's goal is to provide care to our student patients in the safest way possible. Your assistance with this goal is not only required but also greatly appreciated.

Our Allergy Clinic now serves many student patients referred by many different allergy specialists, each with unique forms. Utilizing many different forms is very challenging and has significant potential for error. Therefore, to maximize the safety margin for the student patients, our clinic has developed an allergy extract administration form that we will utilize for every student patient in our allergy clinic.

In order for student patients to receive allergy serum injections at the Ramapo New Jersey Health Services clinic, we require the following:

- Every student patient's initial injection(s) for each vial must be performed at the Allergist's office. This includes any time a new vial is started.
- We will not mix or dilute any extracts; this must be done by the prescribing allergist. We will store extracts in Health Services.
- Each vial must be clearly labeled with:
    - Patient's name
    - Date of birth
    - Name of the antigen(s)
    - Dilution /Strength
    - Expiration date

Ramapo College of New Jersey's Health Center Allergy extract administration form MUST be completed in its entirety and provided prior to a student patient receiving injections. Failure to complete this form in its entirety will result in the patient not receiving allergy injections at Ramapo College of NJ until form is completed. We will not accept any other form or attachments.

These requirements are purely for the safety of our student patients. Failure to comply will delay and potentially prevent utilization of our services.

Sincerely,

Kara Maxsimic, MSN, APN, FNP-C

Acting Associate Director of Health Services Center for Health and Counseling Services

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Allergen Immunotherapy Order Form

For your patient's safety and to facilitate the transfer of allergy treatment to our clinic, this form must be completed to provide standardization and prevent errors. Failure to complete this form will delay or prevent the patient from utilizing our services. Form can be delivered by the patient, mailed, or faxed (see address and fax above).

Patient Name:_____Date of Birth: _____

Physician: _____Office Phone: _____ Secure Fax:_____

Office Address: _____

PRE-INJECTION CHECKLIST

- Is peak flow required prior to injection? NO / YES If yes, peak flow must be >_____ to give injection.
- Is student required to take antihistamine prior to injection? NO / YES

INJECTION SCHEDULE:

- Date of last injection: _____ Dose of last injection: _____
- Begin with _____ (dilution) at _____ml (dose) and increase by _____ every _____weeks according to schedule below:

Dilution					
Vial Cap Color					
Expiration Date(s)	___/___/___.	___/___/___.	___/___/___.	___/___/___.	___/___/___.
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	Go to next Dilution	*Go to next Dilution*	*Go to next Dilution*	*Go to next Dilution*	ml

MANAGEMENT OF MISSED INJECTIONS: (According to number of days from ***LAST*** injection)

During Build-Up Phase	*After Reaching Maintenance*
▪ ___ to ___ days – continue as scheduled	▪ ___ to ___ days – give same maintenance dose
▪ ___ to ___ days – repeat previous dose	▪ ___ to ___ weeks – reduce previous dose by _____ (ml)
▪ ___ to ___ days – reduce previous dose by _____ (ml)	▪ ___ to ___ weeks – reduce previous dose by _____ (ml)
▪ ___ to ___ days – reduce previous dose by _____ (ml)	▪ Over ___ weeks – contact office for instructions
▪ Over ____ days – contact office for instructions	

REACTIONS:

At next visit: Repeat dose if swelling is >_____mm and <_____mm.

Reduce by one dose increment if swelling is >_____mm.

Other Instructions: _____

Physician Signature: _____ **Date: _____**