UAB The University of Alabama at Birmingham

Student Health Services

University of Alabama at Birmingham Student Health Services, 3rd Floor LRC
1714 9th Avenue South
Birmingham, AL 35294
Immunization/Allergy Clinic: Phone (205) 996-4440 |Fax (205) 996- 0148

UAB Student Health Services (SHS) Allergy Injection Protocol and Specialist Consent

Prior to receiving allergy injections at SHS, patients must be established with a SHS provider to review their medical history and medications. An appointment with an SHS provider is required annually thereafter. Orders signed by their immunotherapy-prescribing specialist are required and can be submitted to SHS by fax or mail.

Verbal orders for ongoing dosage adjustments cannot be accepted. There may be need to contact the student's specialist to clarify dosages or to request additional necessary information. Short-term dosage adjustments related to acute illness or local reactions may be taken verbally and documented by SHS Allergy Nurse.

Written Orders/Instructions/Flow Sheets from the specialist **must** contain the following (see attachment for form):

- Patient name and DOB.
- Date of immunotherapy initiation, last injection, dosage, and reaction to last injection.
- Documented proof that the patient has received the first injection without reaction (For patients receiving allergy immunotherapy for venom, they must be at **maintenance dose** before transferring injections.)
- Dosage schedule/Frequency of injections.
- Adjustment of dose/schedule for local reaction.
- Management of local reactions.
- Adjustment of dose for missed or late injections.
- Specialist's office address, telephone number, and fax number.
- **Signature of physician**.
- ICD10 Diagnosis Code for the condition for which the immunotherapy is prescribed.

ALLERGEN EXTRACT VIALS must be labelled with the following:

• Patient's full name and DOB.	• Contents of each vial.
• Strength of each vial.	• Expiration date of each vial.

SHS may decline to administer outside allergy injections for the following reasons:

- Prior anaphylaxis or systemic reaction for any reason related to the condition for which they are treated
- Presence of any contraindication or precaution to the allergy immunotherapy
- Schedule availability/staffing needs based on frequency of injections, particularly if the specialist office is located in the greater Birmingham area
- Lack of communication with specialist's office
- Chronic no-shows for injection appointments (3 or more consecutive no-shows)
- Unprofessional behavior or verbal abuse of any SHS staff by the student

Your signature below confirms that you have granted permission for your patient to have their allergy injections administered at UAB Student Health Services by a registered nurse. Patients are required to carry an epinephrine auto-injector with them on the day of and to the injection appointment. Patients are required to complete a pre-injection screening questionnaire at each appointment for any changes in their health. A physician is on-site at all times. A standard anaphylaxis treatment protocol will be followed in the event of a severe systemic reaction.

Print Specialist's Name:_____
Specialist's Signature (**Required**):_____ Date:_____
Address:_____
Phone:_____ Fax:_____

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Written Allergy Injection Orders (you may add attachment if space is limited)

Patient name and DOB	
ICD10 Code	
Date of immunotherapy initiation	
Date of last injection(s)	
Dosage of last injection(s)	
Reaction to last injection(s)	
Dosage schedule/Frequency of injections.	
Adjustment of dose/schedule for local reaction.	
Management of local reactions.	
Adjustment of dose for missed or late injections.	
Specialist's office address, telephone number, and fax number.	
I attest that this patient has received one or more of these injections (or are at maintenance dose for venom immunotherapy) under my medical supervision and has never had a systemic or anaphylactic reaction to the injection, including anaphylaxis necessitating the use of epinephrine, hospital transport, or prolonged monitoring; widespread rash; dyspnea/wheeze; syncope; seizure; or any other reaction necessitating immediate medical intervention or medical intervention beyond usual supportive care available in an office environment.	
Attest here ☐	Name and Signature of physician.