University Health Service
Case Western Reserve University
10900 Euclid Avenue
Cleveland, Ohio 44106-4901

Phone: 216-368-2453
Fax: 216-368-8530

Allergy Administration Information Sheet

Patient name:____DOB______________________________

Allergist's name____

Clinic Address: ____

Phone#____Fax#____

Pre-medicate: (Y/N)______If yes, what medication?____

Peak flows(Y/N)_____ Parameters: criteria for withholding injections:____________________________________

Alternate arms: (Y/N)____________

Maintenance reached: (Y/N):_____________

Diagnosis:1__________________________ 2___________________________ 3____________________________

When to re-order:____

Interval between injections:____

____

Late/Missed injection protocol:

If on increasing dose:____

____

If on maintenance: ____

____

Directions for Care- UHS will follow clinic protocol for systemic or local reactions (see Instructions for prescribing allergist) if alternative treatment plan desired, please describe below: If localized reaction occurs: _______
____

If systemic reaction occurs: ____

Updated 8/2016