Dear Provider,

Columbia Health Medical Services is committed to providing safe and effective care to all eligible Columbia University students. Our clinic serves numerous students who request administration of allergen serum prescribed by outside specialists. Allergen immunotherapy is an area of care where collaboration with specialists is essential to ensure the safety of our students. To facilitate clear communication and a shared understanding of the treatment plan, we share our policy below, as well as the Allergen Immunotherapy Administration Form that we utilize for every student receiving allergen injections at our clinic.

1. Every patient's initial injection(s) and first dose of new vials must be performed at the allergist office.
2. We will not mix or dilute any extracts; this must be done by the allergist. We will store extracts in the clinic.
3. Each vial must be clearly labeled with:
    a. Patient's name
    b. Name of the antigen(s)
    c. Dilution
    d. Expiration date
4. The Columbia Health Medical Services Allergen Immunotherapy Administration Form (see following page) must be completed by the student's New York State-licensed allergist prior to a patient receiving injections. This form may submitted:
    a. By the patient, at their next visit to Medical Services.
    b. By the patient, by uploading to the "Downloadable Forms" section of the Patient Portal
    c. By the prescribing provider, via secure fax to 212-851-2477.

**Your assistance in completing this form is required to initiate or continue administering allergen injections at Columbia Heath Medical Services.**

We are grateful for your collaboration and your understanding that completion of the Columbia Health Immunotherapy Administration form is required for Columbia Health Medical Services to deliver this service safely. Please contact me with any questions.

Dr. Urmi Desai

Associate Vice President, Medical Services and Medical Director

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# Allergen Immunotherapy Administration 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.

## Patient Information

Legal Name: ____________________________ Date of Birth: _____________________

Physician (allergist): ________________________ NYS physician license number: _______________

Office Number: _________________ Fax: _________________

Office Address: ______________________________________________________________________

## Pre-Injection Checklist

Has patient been prescribed an Epi-Pen: ☐ Yes ☐ No

If the patient has been prescribed an Epi-Pen, why? _________________________________

Is the student required to pre-medicate prior to injection: ☐ Yes ☐ No

If yes, what is the name and dose of the medication? _________________________________

## Injection Schedule

Begin with _____ (dilution) at ______ ml (dose) and increase according to the schedule below.

| Dilution | | | | | |
|---|---|---|---|---|---|
| Antigen | | | | | |
| Vial Color | | | | | |
| Expiration (mm/dd/yyyy) | | | | | |
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*Columbia Health Staff only: Upon completion of schedule, fax form to allergist and scan to chart

## Management of Missed Injections (according to number of days from LAST injection)

| **During Build-Up Phase** | **After Reaching Maintenance** |
|---|---|
| ____ to ____ days: continued 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 instruction | |

## Follow-Up Injection Instructions based on local site response

At next visit: Repeat dose if swelling is greater than ________ mm and less than ________ mm

Reduce by one dose increment if swelling is greater than ________ mm

**Contact Allergist if swelling is greater than ________ mm**

Physician Signature: ____________________ Stamp: _______________ Date: __________________