HEALTH SERVICES
Student Services
SETON HALL UNIVERSITY
Phone: 973-761-9175 Fax: 973-761-9193

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 and submitted in addition to any forms from your office. Failure to complete this form will delay or prevent the patient from utilizing our services. This form can be delivered by the patient, mailed, or faxed to our office.

Patient Information

Patient Name____ Date of birth_____________________________________

Ordering Physician Information

Allergist Name ____Medical License #_____________________________

Office address____

Office Phone____ Office Fax_______________________________________

Allergy History

ICD-10 diagnosis code: _________

Summary of sensitivities/composition of serum:

Date allergy immunotherapy began: __________

Has the patient ever had a systemic reaction? ______ If yes, please provide date and details:

Pre-Injection Checklist

Is the patient required to take an antihistamine prior to injection? _____

Is the patient required to have an EpiPen or similar device at the time of injection? _____

Length of time patient must wait in office following injection__________

Are injection sites rotated? _______

Contraindications to administration:

Additional comments or information we should know about this patient:

Allergist Signature: ____ **Date: __________________**

Revised 6/26/24