UNIVERSITY OF TORONTO

UTSG Health and Wellness
700 Bay Street 14th Floor
Toronto ON M5G 1Z6
Reception: 416 978 8030
Fax: 416 971 2089

Allergy Immunotherapy Intake Form

To be completed by allergist

Patient Name:

DOB:

The above-named patient has requested to have their allergy injections administered at our clinic. Prior to starting injections with us they will meet with one of our physicians to review their allergy regimen. As we have patients from across the world who have been seen by allergists with varying regimens and protocols, completing this form will provide standardization and clarity for our practitioners and thereby assist in optimizing patient safety.

Please ensure all vials, boxes, and allergy administration records have the patient's name and DOB on them.

***Please note: We do not accept verbal orders. ***

1. **Contact information for allergist/clinic if there is a systemic or significant reaction:**

Allergist name: ____

Office hours and days of operation: ____

Best contact number: ____________________________________ ; or, an alternate way to reach you

____

2. **Direction on how to adjust doses for late/missed doses:**

SCIT: Standard schedules, administration techniques, adverse reactions, and monitoring - UpToDate

Adjustments in subcutaneous immunotherapy dosing for gaps in treatment

Build-up phase	
Up to 7 days late	Continue build-up as scheduled
8 to 13 days late	Repeat previous dose
14 to 21 days late	Reduce dose 25%
21 to 28 days late	Reduce dose 50%
Maintenance phase	
2 to 4 weeks late	Reduce dose 75%
>4 weeks late	Reduce by one or more dilutions depending on length of time and patient sensitivity

Please initial here ___ if the suggested schedule adjustments are acceptable to you. If there are other instructions for late and missed doses, please specify here:

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3. **Guidance on Early Doses.** Can this patient have more than 1 dose per week (every 7 days) or less than 30 days, if monthly i.e. sometimes a patient will book a day or two early for their next injection(s)?

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4. **Direction for adjusting dose(s) in the event of a reaction:**
If your practice is to accept all local reactions (including large local reactions) without any dosage change, please indicate and advise on what local reaction (i.e. size) would result in a change of schedule and/or dose.

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Our clinic is equipped to manage local or systemic reactions. Any systemic reactions will be reported to the allergist and the next dose will be held until further direction is obtained.

MD Signature: ______________________________

Date: ______________________________________

Clinic Stamp:

Please **Fax** form to **416 -971- 2089** or give completed copy to the patient to bring to our clinic. Thank you!