Immunotherapy Guidelines
University Health Services
phone: 413.577.5000
fax: 413.577.5440

University of Massachusetts Amherst
150 Infirmary Way
Amherst, MA 01003-9288
www.umass.edu/uhs

This form must be completed and signed by the prescribing physician before injections can be administered.

Name: _____ D.O.B: _____

Original immunotherapy start date: _____ Expected completion date: _____

History of systemic or other serious reaction? Yes (describe): _____ No: _____

History of asthma? Yes (describe): _____ No: _____

Current medications: _____

Date of last injection: _____ Dose: _____ Reaction: _____

Contents Vial #1: _____ Dilution: _____ Exp. Date: _____

Interval	Date	Dose	Site	Reaction	Signature	Exp. Date

Contents Vial #2: _____ Dilution: _____ Exp. Date: _____

Interval	Date	Dose	Site	Reaction	Signature	Exp. Date

Contents Vial #3: _____ Dilution: _____ Exp. Date: _____

Interval	Date	Dose	Site	Reaction	Signature	Exp. Date

SEE REVERSE FOR LATE ORDERS, M.D. SIGNATURE

Immunotherapy Guidelines (pg. 2)
University Health Services
phone: 413.577.5000 • fax: 413.577.5440

Name: _____ D.O.B: _____

Contents Vial #4: _____ **Dilution:** _____ **Exp. Date:** _____

Interval	Date	Dose	Site	Reaction	Signature	Exp. Date

Contents Vial #5: _____ **Dilution:** _____ **Exp. Date:** _____

Interval	Date	Dose	Site	Reaction	Signature	Exp. Date

Doctor's orders if overdue by:

1 week: _____

2 weeks: _____

3 weeks: _____

4 weeks: _____

Doctor's orders (for fresh serum) – Reduce dose: Yes No Amount: _____

Doctor's orders (for pollination season) – Reduce dose: Yes No Amount: _____

Maintain or reduce dose for reaction: _____ **Call allergist:** _____

Other orders for this patient: _____

_____

Physician name: _____ Address: _____

Tel. #: _____ Fax #: _____

M.D. signature: _____

University Health Services M.D. reviewer: _____