Drexel Student Health Center
3401 Market Street, Suite 105 B
Philadelphia, PA 19104
Phone: (215) 220-4700
Fax: (215) 220-4705

Dear Allergy Patient,

First, we would like to welcome you to the Drexel Student Health Center Allergy Clinic.

We know that Drexel students have very busy schedules, and we do our best to accommodate everyone's schedule. Our most important objective at the Student Health Center is patient safety. Therefore, we ask that you comply with the following allergy policy to ensure safe, efficient, and effective care.

1. Take the attached forms to your Allergy Provider:
   - Request and Consent for Administration of Allergy Immunotherapy
   - "Allergy Clinic Policy and Procedures"
     a. All orders must be completed in legible English.
     b. Completed forms should be returned to Student Health with allergy serums.
     c. We cannot administer allergy injections until forms are properly completed and received. This is to ensure proper communication of information for your safety.
2. Please review and complete the "Student Allergy Injection Information and Consent."
3. Bring your allergists' orders, completed forms and all refrigerated serums to Drexel Student Health. New patients must be cleared by a Drexel Student Health Provider before scheduling injections.
4. The Drexel Student Health Center does not give the initial dose of allergen immunotherapy.

GETTING YOUR ALLERGY SHOTS

1. Know your allergist's office hours and schedule your appointment with us on days and times that your allergist's office is open which enables us to communicate with your allergist during your appointment if any questions arise.
2. All allergy serum recipients will be required to check out with a provider 30 minutes after administration. This waiting period is important to assess any reactions after allergy injections.
3. No other injections such as immunizations will be given the same day as an allergy shot.
4. Students will be required to sign a No-Show Agreement. More than 3 "NO SHOW" appointments in the semester will result in Student Health no longer administering injections.
5. You may call our office to schedule your appointment at least 24 hours in advance. We do not accept walk-in appointments for this service.
6. When you need more serum, it is your responsibility to obtain it from your allergist with the updated orders and forms.

Sincerely,

Drexel Student Health Providers and Staff

ALLERGY CLINIC POLICY AND PROCEDURES

Policy:

- Patients requesting administration of immunotherapy extracts will have their Allergist complete a form titled " Request and Consent for Administration of Allergy Immunotherapy."

- Referring Allergist will provide:

1. Allergen Extract for injection.
2. Detailed protocols for dosing and dose adjustments including schedules for: escalation and maintenance dosing, the use of new vials, during seasonal exposures, if the constituents of the allergen immunotherapy extract have changed, missed doses and when reactions occur.

- The referring Allergist is responsible for the management of the individual immunotherapy and modification of dosing schedules. The Drexel Student Health Center (DSHC) will periodically send updated treatment history back to the referring allergist if outlined per the protocol provided by the referring Allergist.

- Allergen immunotherapy will not be administered unless a Drexel Student Health Attending Physician is present and readily accessible in the office.

- Treatment of reactions will be done under Drexel Student Health Protocol.

- The Drexel Student Health Center will provide the service of storing allergen extracts for patients between injections as described in the following procedures. DSHC is not liable for the compromise in the integrity of the medication due to handling before DSHC receives the medication or for loss or compromise of integrity due to power outage, storage equipment failure, or catastrophic event.

- Consents and referral agreements expire at the end of each academic year (Month and Date).

- DSHC expects the referring Allergist to reevaluate the patient at least annually.

Procedures:

Storage of Extract

- The extract is to be stored in containers clearly indicating the patient's name and labeled to identify the contents of the vial.
- The extract is to be stored, refrigerated, and kept between 3 Degrees C and 6 Degrees C (37.4 Degrees F and 42.8 Degrees F)
- If the extract is exposed to heat or frozen, DSHC will contact the referring Allergist for instructions and document the contact and instructions.

Administration of Extract

- A Drexel Student Health attending physician must be present and readily available during the entire allergy injection and observation period before extract can be administered.
- Injections are given subcutaneously using a 1ml syringe with a 26 or 27-gauge needle.
- Injections should be given in the posterior portion of the middle third of the upper arm at the junction of the deltoid and triceps muscles.
- The syringe should be aspirated to check for blood return in the syringe before injecting. If blood is present, the solution should not be injected, and the syringe removed and discarded in an appropriate container.
- The patient must remain and be observed for 30 minutes after an injection.

Dosage and Dose Adjustment

- Dosage changes are indicated 1) during escalation and maintenance dosing, 2) the use of new vials, 3) during seasonal exposures, 4) if the constituents of the allergen immunotherapy extract have changed, 5) missed doses, and 6) if reactions have occurred. Detailed dose and dose adjustment for the above-mentioned scenarios are per the schedule provided by the referring Allergist.
- Any questions or clarifications should be made to the referring Allergist.

Contraindications

- Injections should be postponed if the patient is ill, febrile, has symptomatic asthma, or has sunburn or irritation at the injection site.

- Injections should not be given to patients taking beta-blockers or monoamine oxidase inhibitors (MAOI's).

- Caution advised-appropriately revised dosage schedules must be obtained from the referring Allergist to continue injection during pregnancy.

Documentation

- Every visit is to be charted in the DSHC Allergy Immunotherapy Log:
    1. Date of injection
    2. Amount of serum given
    3. Injection site
    4. Inspection and description of injection site after 30 minutes (e.g. negative, inflammation, swelling, wheal and glare size in mm of longest diameter, etc.)

- The treatment record provided by the referring Allergist is to be completed for the visit and kept in a separate Allergy Clinic chart.

- Anytime the treatment record is sent to the referring Allergist, a note should be placed in Allscripts and a copy of the treatment record sent should be scanned into the EHR.

Treatment of Local Reactions

- Usually no treatment is required for local reactions other than application of an ice pack and adjustment of future doses.
- For local reactions greater than 2 inches, topical steroids may be applied.
- For local itching, redness and large swelling, an oral antihistamine such as diphenhydramine 50mg may be given.

Acute management of Anaphylaxis

Anaphylaxis Supplies and Equipment List: tourniquet, sphygmomanometer, Epi-Pens (1:1,000 for IM injection), oxygen, oxygen mask, latex-free gloves, diphenhydramine (oral 25mg), albuterol inhalation solution, and nebulizer.

- An Epi-Pen will be injected in the anterior or lateral thigh.
- 911 will be called and the patient will be transferred to the emergency room.
- While awaiting emergency assistance:
  Place tourniquet lightly above allergen injection site.
  Stay with the patient and monitor vital signs every 2-5 minutes.
  Place patient in the supine position with feet elevated.
  Give Oxygen (6-8L/min) via mask.
  Consider diphenhydramine 25 mg PO x 1 for itching and urticaria only.
  Consider albuterol via nebulizer if patient has bronchospasm.

I am aware of the anaphylaxis protocol at the Drexel Student Health Center. I have reviewed this protocol and supplies list and agree with their treatment plan of a potential anaphylactic reaction to the following patient:

Prescribing Physician's Signature: ______________________________

Prescribing Physician's Name (Printed): ______________________________

Date: ______________________________

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ALLERGIST'S REQUEST AND CONSENT
FOR
ADMINISTRATION OF ALLERGY IMMUNOTHERAPY

Patient's Name:______________________________ DOB: ____________________

Attention Prescribing Allergist's Office:

The above-named student requests the Drexel Student Health Center to provide allergy immunotherapy prescribed by you. Patient safety is of the utmost importance; therefore, the prescribing allergist **must complete the standardized form below ("see order" or "see schedule" is NOT acceptable).** Please note that the Student Health Center policy states that each student is responsible for retrieving his/her serum vial(s) at the end of each quarter. The Student Health Center is NOT able to mail vials of serum. Your timely response to the items below is greatly appreciated.

ORDERING PROVIDER INFORMATION (Please Print/Type):

Name:______________________________ **Phone Number:**____________________

Office Address:______________________________ Fax Number:____________________

City, State:______________________________ Zip Code:____________________

Office Hours: ____

Patient's Name:.. DOB: ....

In addition, policy requires that:

- o Each vial is labeled with the student's name and date of birth.
- o A listing of the extracts in each vial accompanies each vial.

Vial ____

Vial ____

Vial ____

Vial ____

Vial ____

Vial ____

- o **The expiration date for each vial is included.**

Vial ________/____/______

Vial ___:_____/____/______

Vial ___.______/____/______

Vial ___:_____/____/______

Vial ___:_____/____/______

Vial ________/____/______

Patient's Name:.. DOB: ....

- **The Drexel Student Health Center does not give the initial dose of allergen immunotherapy. Please give the date of the most recent injection given at your office.**

  __ /___ /__ Arm: Right/Left Reaction: __________________________

  ____/___ /__ Arm: Right/Left Reaction: __________________________

  ____/___ /__ Arm: Right/Left Reaction: _ _ _ _ _ _ _ _ _ _ _ _ _ _

  ___/___ /__ Arm: Right/Left Reaction: __________________________

  ____/___ /__ Arm: Right/Left Reaction: __________________________

  ____/___ /__ Arm: Right/Left Reaction: __________________________

- As per the attached order form, Instructions for administration of immunotherapy should include:

1. Injection frequency
2. Injection dose
3. Incremental dose increase (in ML)
4. Acceptable interval for missed dose (from the date of last shot)
5. How to handle missed doses that exceed acceptable interval
6. How to handle immediate or delayed local reactions in terms of subsequent dosing

SEE ORDER" or "SEE SCHEDULE" IS NOT ACCEPTABLE

- Any student that has significant systemic reaction will not be able to receive subsequent injections at the Student Health enter until evaluated by the prescribing physician and written recommendations are provided to the health center for subsequent dosing.
- For asthmatics, baseline peak flow should be provided.
- <u>**For any student with a history of anaphylaxis or systemic reaction to allergen exposure, a prescription to Epi-Pen is required. The student should be able to demonstrate understanding of when and how to use the Epi-Pen.**</u>

Patient's Name:________________________DOB: ________________

-Have you prescribed Epi-Pen for this patient? YES/NO (Please circle)

-Has your office instructed the student about Epi-Pen usage? YES/NO (Please circle)

-Has the patient experienced any significant local or systemic reactions to allergy injections? If yes, please give details: ________________________

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-Further Instructions: ____

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Prescribing Physician Signature *Date*

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 to provide standardization and prevent errors.

Patient Name: ________________________________Date of Birth: ____________________

Ordering Physician: __________________________Phone: ____________Secure Fax:____________

PRE-INJECTION CHECKLIST:

- Is peak flow required prior to injection? NO YES: **If yes,** peak flow must be >____ L/min
- Is the student required to have taken an antihistamine prior to injection? NO YES

INJECTION SCHEDULE:

Begin with ______________(dilution) at __________ml (dose) and increase according to the schedule below.

Dilution					
Vial cap Color					
Expiration Date(s)					
Frequency					
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	Go to next Dilution	ml	ml	ml	ml
		Go to next Dilution	ml	ml	ml
			Go to next Dilution	ml	ml
				Go to next Dilution	ml
					ml

MANAGEMENT OF MISSED INJECTIONS: (According to# of days from ***LAST*** injection)

During Build-Up Phase	***After Reaching Maintenance***
__to__ days - continue 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 instructions	

REACTIONS:

At next visit: Repeat dose if swelling is >________mm and <__________mm.

Reduce by one dose increment if swelling is >____________mm.

Physician Signature: ______________________________________ Date: ____________