ALLERGY CLINIC REFERRAL FORM

The following UHC guidelines establish requirements for our care, and are designed with your patient’s safety in mind.

- All vials must be clearly labeled with the patient’s name, date of birth, contents, dilution, and expiration date.
- Instructions must include build-up and maintenance schedule, dose, frequency, and directions for dose adjustments if needed for local reactions or if the patient is off-schedule.
- Vials and required forms may be hand delivered or mailed to the address below.

**** Attach a copy of the signed informed consent for immunotherapy from your office. The consent must accompany this form before any injections can be administered in our clinic. *****

Environmental allergies:

Food allergies:

Drug allergies:

History of systemic reaction from allergy injections:

Does patient require pre-medication?
Name of medication:

Has patient been instructed to carry an EpiPen with them on injection days?

Does patient require a peak flow? If yes, then minimum required to receive an injection:

Physician Name (please print) ____________________________________________________________

Physician Signature ________________________________________ Date _______________________

Phone ___________________________ Extension __________________ Fax __________________________

☐ I have attached a copy of the signed Informed Consent from my office to accompany this referral.

University Health Center – Allergy Clinic

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