University Health Center
*Student Affairs*
UNIVERSITY OF GEORGIA

Name _____
UGA ID _____
Date of Birth _____

# 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?**<br>**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** **Phone: (706) 542-5575**

**University of Georgia** **Fax: (706) 583-8255**

**55 Carlton Street**

**Athens, GA 30602-1755**



**Reviewed: 5/2019, 7/2021**
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