



William & Mary
Student Health - McLeod Tyler Wellness Center - 240 Gooch Drive - Williamsburg, VA 23185
Phone: 757-221-4386 Fax: 757-221-1245

Dear Allergy provider,

The W&M Student Health Center's goal is to provide care needed by our students in the safest way possible. Your assistance with this goal is not only required, but also greatly appreciated.

Our staff provides allergy injections to students referred by numerous allergy specialists across the country, each with their own unique form. Without a consistent format, the possibility for omissions or errors may increase. Therefore, to maximize the safety margin for our students, our clinic has developed an allergy immunotherapy administration form that we will utilize for every student patient in our allergy clinic.

In order for students to receive allergy immunotherapy at the W&M Student Health Center, we require the following:

- Initial injections must be performed at the Allergist's office
- If there has been a four month lapse in injections, student must return to Allergist office to resume injections before being able to continue immunotherapy at W&M
- We will not mix or dilute any extracts; this must be done by the prescribing office. We will store extracts at the SHC.
- Each vial must be labeled with:
 - Patient's name
 - Date of birth
 - Content of vial(s)
 - Dilution/strength
 - Expiration date
- The Allergy Immunotherapy administration form must be completed prior to the patient receiving injections at the W&M SHC.

Vials are accepted by drop off and mail M-F 9am-5pm unless there is a closure. Contact us in advance to ensure the SHC will be open.

All shipped packages should be addressed as follows:

The College of William & Mary
Student Health Center
Attn: Student's name
240 Gooch Drive
Williamsburg VA 23185

Thank you,

David Dafashy, MD
SHC Medical Director



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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. **Failure to fully complete this form and attach requested documents will delay or prevent the patient from utilizing our services.** This form can be delivered by the patient, mailed, faxed or uploaded to the patient portal by the student.

Patient Name: _____ DOB: _____

Physician: _____

Office Address: _____

Office phone: _____ Fax: _____

Does this patient have a history of anaphylaxis with previous allergy injections? _____

Orders

- Is peak flow required prior to injection? NO / YES
- **If yes**, peak flow must be > _____ to give injection.
- Is lung assessment required prior to injection? NO / YES
- Is student required to take antihistamine prior to injection? NO / YES
- Is student required to have EpiPen at the time of injection? NO / YES

Other Instructions:

Injection records attached? NO/ YES

Late/missed injection records attached? NO / YES

Localized reaction instructions attached? NO / YES

Physician Signature: _____ Date: _____