REFERRAL AGREEMENT FOR ADMINISTRATION OF ALLERGY IMMUNOTHERAPY

Patient Name: ____ DOB: _______________________
NKU ID#_______________________________________

Dear Doctor:

Your patient has requested to receive allergy immunotherapy injections at Northern Kentucky University's Health, Counseling and Student Wellness. Please fill out the form below. **This information is required for the administration of allergy immunotherapy.**

1) Allergies/Diagnosis:____
2) History of previous reactions/anaphylaxis: ____
3) Current vial strength, content, dose, expiration:
   a. ____
   b. ____
   c. ____
4) Dosage reduction for new vials:____
5) Dosage Reduction for lateness:____
6) **Is this patient required to have an EpiPen with them when they get their injection(s)?** Yes No

Physician Signature _______________________________________Date______________________

Board Certified Allergist: _______ Yes _______ No

Printed Name____

Phone_________________________________ Fax: _______________________________________

Practice Address/ Stamp: ____

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