SOUTHERN ILLINOIS UNIVERSITY EDWARDSVILLE HEALTH SERVICE
0222 STUDENT SUCCESS CENTER
EDWARDSVILLE IL 62026-1055 TELEPHONE: 618-650-2842 FAX: 618-650-5839

Patient: Last Name **First Name** **SIUE ID #**

Please complete Allergy Injection orders for the following vials:

Injections will not be given until this form is completed and returned to our office (please do not say "see attached")
Send your treatment record and the patient's serum along with this form (unless we have it already).

Vial #	Contents	Strength	Frequency	Expiration Date	Date of Last Injection

Is a 20-minute post-injection waiting period acceptable to you or should we require your patient to wait longer?
☐ Yes ☐ No If no, how long?_____

Building (Series) Schedule – include minimum/maximum day range: _____

_____

_____

Maintenance Schedule – include minimum/maximum day range: _____

_____

_____

Adjustment for Missed and/or Off-schedule Injections: _____

_____

_____

Instructions for Local Reactions:_____

_____

Instructions for Systemic Reactions:_____

_____

Physician Name (printed)	Office Phone	Office Fax

Office Address Street	City	Zip Code

Office Hours of Operation:

_____

Physician Signature_____ **Date**_____

Reviewed by_____ Date_____
SIUE Health Service RN