



PHYSICIAN ORDERED
ALLERGY SERUM

_____ has requested Hendrix Health Center to administer his/her allergen injections.

Physician: Please complete and sign this physician order form for administration of allergy extracts. Include dosage schedule, and instructions for prevention and treatment of reactions. [Note: Hendrix Health Center does not give injections to patients who have had a severe systemic or severe local reaction. He/she will be referred to a local allergist.]

Allergen content: _____

Amount of allergen per injection and dosage scheduling (may attach): _____

Frequency of allergen injections: _____

Injection site (same or rotate arms): _____

Procedure when injection is late: _____

Procedure when starting a new bottle of allergen: _____

Procedure when allergen has passed expiration date: _____

Date of next scheduled appt.: _____

Has this patient had any severe local or systemic reactions when receiving allergy serum?

Does this patient have any chronic or severe illness which might affect general health or desensitization schedule? Please indicate:
Asthma _____ Cardiac _____ Other _____

Physician's signature _____ Date _____

Clinic Phone Number(____) _____

Clinic Address; _____

