UNIVERSITY OF NOTRE DAME

University Health Services

University Health Services strives to provide care needed by our student patients in the safest way possible. Your assistance with this goal is not only required but also greatly appreciated.

Our Allergy Clinic now serves over 100 student patients referred by over 70 different allergy specialists. Each allergy specialist has a unique order form they use in their office. Navigating over 70 different forms is very challenging. It can be confusing and has significant potential for error. Therefore, to maximize the safety margin for the student patients, our clinic has developed our own allergen immunotherapy order form that we will utilize for every student patient in our allergy clinic. We will continue to document the administration of injections on your office forms, but the order form will look the same for all allergy immunotherapy student patients.

In order for student patients to receive allergy immunotherapy at the UHS Allergy Clinic, we **require** the following:

1) Every student patient's initial injection(s) must be performed at their Allergist's office.

2) We will not mix or dilute any extracts; this must be done by the prescribing allergist. We will store extracts in the Allergy Clinic in a temperature monitored refrigerator.

3) Each vial must be clearly labeled with:
    a. Patient's name
    b. Patient's date of birth
    c. Name of the antigen(s)
    d. Dilution
    e. Expiration date

4) **We prefer you to complete our University Health Services Allergen Immunotherapy Order Form and return to the Allergy Clinic prior to a student patient receiving injections. This will allow all student to have similar documents for safety purposes.**

Please do not return our form with "see attached" which then refers to the same allergy serum order form you currently use.
We appreciate the extra work your office will perform as this will help us maximize safety and assist you in the overall care of the patients you have entrusted to us while away at college.

Sincerely,

University Health Services

UNIVERSITY OF NOTRE DAME

University Health Services

TO: Notre Dame **Students** on Allergy Immunotherapy

FROM: Kathryn Cox Cohoon, MD
Medical Director

RE: Allergy Immunotherapy

University Health Services at the University of Notre Dame (located in Saint Liam Hall) is pleased to administer allergy injections to our students who are under an immunotherapy regimen prescribed by their private providers.
Our records indicate that you are either a new or returning student receiving allergy injections. To assure a standard of quality care, we ask for your cooperation. The continuation of your therapy at University Health Services requires specific instructions from your provider. It is imperative for us to have this information before we will provide care for you.
Please give your provider the enclosed letter and verification forms. You are responsible for obtaining the following from your provider prior to the beginning of each academic year.

a. Date and dose of last injection.
b. Vials that are labeled/coded with your name, contents of vial, dilution and expiration date.
c. Single dose vials are to be numbered or dated.
d. The UHS Allergy Immunotherapy Order Form that clearly states the recommended doses, interval of injections, route and site of administration.
e. Instructions for missed/late injections, new vials and reactions.
f. The provider's signature who is authorizing the therapy.
g. Diagnosis for Allergy Immunotherapy care

IT IS YOUR RESPONSIBILITY TO BE CERTAIN THAT ALL THE INFORMATION REQUESTED IS WITH YOUR EXTRACTS WHEN YOU ARRIVE ON CAMPUS. INCOMPLETE INFORMATION MAY RESULT IN A DELAY IN TREATMENT.

You may bring in the extracts and instructions at your convenience and schedule your first appointment during the academic year online at http://onlinestudenthealth.nd.edu. Please note however, that allergy injections are given by appointment only.

For your initial injection of each academic year at Notre Dame, please make a 30-minute appointment. 15-minute appointments are sufficient after this. It is MANDATORY for you to remain in our clinic for 30 minutes after each injection, therefore the total time you will spend in our clinic may be an hour. Non-compliance will result in termination of services at our clinic.

If you or your provider has any questions regarding our policy and procedure for allergy injections at University Health Services, please call us at 574-631-7497.

UNIVERSITY OF NOTRE DAME

University Health Services

TO: **PROVIDER** Prescribing Allergy Immunotherapy to Notre Dame Student

FROM: Kathryn Cox Cohoon, MD
Medical Director

RE: Allergy Immunotherapy

University Health Services, at the University of Notre Dame, provides the service of administering allergy injections to those students who are presently being treated by an Allergist. We will NOT be responsible for skin testing, the initial dose for new patients or those resuming therapy after an extended delay in treatment.

The administration of extracts is based on our UHS Immunotherapy Order Form prior to the beginning of each academic year. The continuation of therapy requires specific instructions. The following criteria are necessary:

A. Date and dose of last injection.
B. Vials that are labeled/coded with patient name, contents of vial, dilution and expiration date.
C. Single dose vials are to be numbered or dated.
D. Guidelines that clearly state the recommended doses, interval of injections, route and site of administration. When injections can be given more than once a week, please note specific time frame between doses.
E. Dosage adjustment instructions for missed/late injections, reactions and ordering new vials. Please note if local reaction is defined by size of induration and/or erythema.
F. A provider's signature authorizing the therapy.
G. Diagnosis for Allergy Immunotherapy care.

INCOMPLETE INFORMATION WILL RESULT IN A DELAY IN TREATMENT

Injections will be given only when a provider is on the premises. All patients will be expected to remain in our clinic for 30 minutes following the injection(s). Any significant reaction and its treatment will be reported to you.

If the patient has had a previous systemic reaction, please share that information with us.

Optimum results of therapy depend on patient compliance plus clear and concise guidelines from you. Please complete our UHS Allergy Immunotherapy Order Form to allow standardization for all students in our clinic. Together we can provide the best possible patient care.

Should you have any questions regarding our policy and procedure for allergy injections at University Health Services, please feel free to contact us at 574-631-7497.

UNIVERSITY OF NOTRE DAME

University Health Services

INFORMATION FOR PATIENTS RECEIVING ALLERGY IMMUNOTHERAPY

1. Allergy injections are given by appointment only and can be scheduled online during the academic year at http://onlinestudenthealth.nd.edu or by calling 574-631-7497.

2. A pre-therapy questionnaire will be completed at each visit before any allergy injections are given. Any problems from previous injections, present day illnesses, asthma exacerbation/symptoms or the use of Beta-blocker medications will be addressed.

3. You are expected to wait in University Health Services (UHS) for 30 minutes following the injection(s), and report any reactions that occur:
   a. LOCAL: may consist of redness, itching and/or swelling at site of injection
   b. SYSTEMIC OR GENERALIZED: Report any distress **IMMEDIATELY**. Symptoms may include, but are not limited to hives, tightness in chest, coughing, wheezing, excessive sneezing, itching, extreme redness in face and/or eyes, nausea, dizziness, headache or fainting.
   c. Any questions please check with the nurse.

4. A copy of your injections schedule will be provided upon request.

5. Your serum is stored in a temperature monitored refrigerator in the UHS department. Expired serum will always be discarded. Unless you are receiving injections at UHS over the summer months, all unclaimed serum will be discarded after July 1. UHS does not mail out serum. Allergy medical records are maintained at UHS according to State of Indiana law.

6. Non-compliance with instructions given will result in the discontinuation of your allergy injection(s) at University Health Services.

I have read the above information and acknowledge its contents.

_____	_____	_____
Printed Name	Patient Signature	Date

Exhibit I

UNIVERSITY OF NOTRE DAME

University Health Services

To: _____ Date_____

Fax Number: _____

Dear Provider:

University of Notre Dame Health Services has received instructions and schedule for:

_____ _____

Patient Name DOB

Please provide the following information for our records as we provide continued allergy injections for your patient while they are attending the University of Notre Dame:

- ☐ Type of extract or dilutions of extract
- ☐ Recommended interval of injections
- ☐ Recommended maintenance dose or dose schedule
- ☐ Expiration date of extract
- ☐ Guidelines for reactions, including dose adjustments due to any reactions
- ☐ Method we should use to obtain new extract when needed
- ☐ Guidelines for dose adjustments due to lapses in therapy
- ☐ Signature of Prescribing Provider authorizing therapy

_____

- ☐ Other: _____

_____

University Health Services will await your written clarification of these matters before attempting to provide care for your allergy patient. Please send your recommendations to University Health Services, University of Notre Dame, Notre Dame, Indiana 46556-5693 or FAX to (574) 631-6047.

Thank you.

University Health Services
574-631-7497

Exhibit II

UNIVERSITY OF
NOTRE DAME
University Health Services

DATE: _____

TO: _____

FAX: _____

RE: _____ DOB: _____

Dear Provider,

Please verify the recent phone order regarding the above patient and his/her dosage change or adjustment.

_____

_____

_____

_____

_____
(Provider Signature)

Please correct and sign, then fax back to us at (574) 631-6047. If you have any questions, we can be reached at (574) 631-7497.

Thank you,

University Health Services

Exhibit III

ALLERGEN IMMUNOTHERAPY SERUM CHECKLIST

_____ ___ _____ _____

NAME ND ID# DOB DATE

_____

DIAGNOSIS

Complete checklist before administering allergy injections.
This checklist is completed yearly and whenever new vials of extract/serum are received.

1. Number of vials 1 2 3 4 5 6					
2. Vials are labeled with PATIENT NAME	YES NO	YES NO	YES NO	YES NO	YES NO
3. EXPIRATION DATES are included	YES NO	YES NO	YES NO	YES NO	YES NO
4. SINGLE DOSE vials are numbered or dated N/A_____	YES NO	YES NO	YES NO	YES NO	YES NO
5. Vials are labeled/coded as to CONTENT and correspond with written directions	YES NO	YES NO	YES NO	YES NO	YES NO
6. Vials are labeled/coded as to DILUTION	YES NO	YES NO	YES NO	YES NO	YES NO
7. ROUTE and SITE of administration are indicated	YES NO	YES NO	YES NO	YES NO	YES NO
8. RECOMMENDED DOSES are indicated	YES NO	YES NO	YES NO	YES NO	YES NO
9. INTERVAL between injections is indicated	YES NO	YES NO	YES NO	YES NO	YES NO
10. Instructions for MISSED/LATE injections are present	YES NO	YES NO	YES NO	YES NO	YES NO
11. Instructions for local or systemic reactions are present	YES NO	YES NO	YES NO	YES NO	YES NO
12. Instructions for ordering NEW VIALS are present	YES NO	YES NO	YES NO	YES NO	YES NO
13. PROVIDER name and CLINIC authorizing therapy are present, with phone and fax number listed	YES NO	YES NO	YES NO	YES NO	YES NO

*If there are any items checked "NO", clarification will be necessary. In some instances this may delay care. Upon clarification, the corresponding "YES" box will be checked and dated by the RN.

RN completing this checklist: _____

Exhibit IV

UNIVERSITY OF NOTRE DAME

ALLERGY INJECTION PROTOCOL

1. Sign on to EMR.
2. Click on “Appointments.”
    a. Check each chart for:
        i. Injection schedule and interval of injections.
        ii. Crosscheck this with last dose given to assure proper dosage. If interval is too long, follow the allergist’s schedule for decreasing amount. If unclear or interval falls longer than orders include, place a call to the allergist’s office and ask to speak to the nurse. (Identify yourself as ND Allergy Nurse.)
        iii. Check reaction orders for each individual patient.
    b. Check serum in the refrigerator:
        i. For expiration date.
        ii. Check volume of serum. Note if new serum needs to be ordered.
    c. When student arrives:
        i. Recheck orders.
        ii. Assess health status of student. Document findings on “Pre-Therapy Questionnaire” (Exhibit VIII). Do not give if:
            1. Temp>100
            2. Appears acutely ill
            3. Asthma or hay fever symptoms
            4. Had tetanus or other immunization in past 24 hours, excluding influenza vaccine.
            5. If any swelling remains from last injection
            6. Taking any beta-blocker medications.
        iii. Ask patient to verify that vials are his/hers. Draw up proper dosage, recheck with orders, and give injections Sub-q. It should already be noted on the Allergy Injection Schedule regarding special instructions, including which arm, dry needles, etc. Use cotton ball to wipe site after injection, applying pressure for 10-20 seconds. DO NOT RUB INJECTION SITE.
        iv. Use Benadryl cream, ice, and/or band-aids per patient comfort and preference
        v. Have student go to waiting area for 30 minute wait.
        vi. Document on Allergy Injection schedule and allergist sheet.
        vii. Complete EMR documentation requirements.
        viii. After 30 minutes, check injection site and document any reaction on brown sheet and allergist sheet.
        ix. Confirm next appointment with patient and in EMR.
        x. Any reactions requiring significant medical intervention should be noted on the patient chart, as well as filing an “Adverse Event“ organizational report.

Exhibit V

University of Notre Dame Health Services

ALLERGY INJECTION SCHEDULE

Name NDID DOB

Diagnosis:_____

EXTRACTS

A_____

B_____

C_____

Always change needle after drawing up serum

Alternate Arms	Yes	No
Benadryl cream/Spray	Yes	No
Ice	Yes	No
Bandaids	Yes	No

Additional Information: Frequency: Pt Year:

Epi_____SQ IM

Last dose:

Arm Code: ↑ = upper

R = Right → = middle

L = Left ↓ = lower

Date	Time	Extract	Dilution	Exp Date	Dose & Site	Peak Flow	Time of Check	Remarks

Exhibit VI

UNIVERSITY OF NOTRE DAME

University Health Services

RECEIPT OF EXTRACTS

1. Place extracts in a plastic bag. Label the bag with the patient's name and DOB and place it, in alphabetical order, in the boxes in the refrigerator.
2. Obtain Allergist's instructions from the student. Date and initial the papers in lower right-hand corner.
3. Note patient name, phone number, year in school, and preferred appointment time & day on Allergy Patient Listing.
4. Initiate Allergy Injection Schedule and Immunotherapy Checklist (Exhibits VI and IV) by checking off each listed item. The patient does not need to wait while this is being done. Initiation of these forms will expedite their first visit. If information is missing from the Allergist's instructions, (item checked "no" on the checklist) start the form letter to the doctor to request the missing information.
5. With yellow highlighter, mark the areas of importance on the Allergist instructions.
6. Place all forms and instructions in a plastic folder and place tab with patient's name on folder.
7. Schedule first appointment in EMR, under Travel/Allergy screen. Appointment availability is indicated in EMR and is subject to change.
8. If patient is not sure of their schedule, make sure to note their phone number on Allergy Patient Listing. Give them a University Health Services (UHS) card with contact info, and remind them that it is their responsibility to contact UHS to set up their appointment.

If you have any questions, please contact Assistant Director, Clinical Operations

Note:

a. At a minimum, complete numbers 1, 2, 3, and 6.
b. Keep the mailing containers and store alphabetically in cabinet above sink in Allergy office.

Exhibit VII

UNIVERSITY OF NOTRE DAME

University Health Services

ALLERGY PATIENT LISTING

Name (Last, First)	Phone Number	Year in school

University Health Services, University of Notre Dame

Student's Pre-Therapy Questionnaire

To be completed at each Allergy Immunotherapy visit

_____

Name **NDID** **DOB**

Date																				
Any problems with your last injections?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Any fever of 100 or more or wheezing the past 24 hours?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Any exercise within 1 hour before your shot/s today?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
List here ALL meds used daily for Allergies and meds taken for any other medical diagnosis.	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Are you required to carry an EpiPen? Exp. Date:	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Are you currently taking any Beta-Blockers? (list available)	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Staff initials																				

Staff initials/signature

Exhibit VIII

UNIVERSITY OF NOTRE DAME

University Health Services
100 St. Liam Hall, Notre Dame, IN 46556
Phone: 574-631-7497, Fax: 574-631-6047

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 complete this form will delay or prevent the patient from utilizing our services. Form can be delivered by the patient, mailed, or faxed (see address and fax above).

Patient Name:_____ Date of Birth: _____ Dx: _____

Physician: _____ Office Phone: _____ Secure Fax: _____

Office Address: _____

PRE-INJECTION CHECKLIST:

- Is peak flow required prior to injection? NO ☐ YES: ☐ **If yes**, peak flow must be **>** _____L/min to give injection.
- Is student required to have taken an antihistamine prior to injection? NO ☐ YES ☐

INJECTION SCHEDULE:

Date & Dose of last injection _____

Begin with _____ (dilution) at _____ ml (dose) and increase Q_____(frequency) according to the schedule below.

Dilution					
Vial Cap Color					
Expiration Date(s)	___/___/___.	___/___/___.	___/___/___.	___/___/___.	___/___/___.
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	Go to next Dilution	*Go to next Dilution*	*Go to next Dilution*	*Go to next Dilution*	ml

MANAGEMENT OF MISSED INJECTIONS: (According to number of days from ***LAST*** injection)

During Build-Up Phase	***After Reaching Maintenance***
▪ ___ to ___ days – continue as scheduled	▪ ___ to ___ days – give same maintenance dose
▪ ___ to ___ days – repeat previous dose	▪ ___ to ___ weeks – reduce previous dose by _____ (ml)
▪ ___ to ___ days – reduce previous dose by _____ (ml)	▪ ___ to ___ weeks – reduce previous dose by _____ (ml)
▪ ___ to ___ days – reduce previous dose by _____ (ml)	▪ Over _____ weeks – contact office for instructions
▪ Over _____ days – contact office for instructions	

REACTIONS:

At next visit: Repeat dose if swelling is >_____mm and <_____mm.

Reduce by one dose increment if swelling is >_____mm.

Other Instructions: _____

_____

Physician Signature: _____ Date: _____

Adapted with permission from Dr. A. Guertler at JMU

Exhibit IX