



McKINLEY HEALTH CENTER
UNIVERSITY OF ILLINOIS AT URBANA-CHAMPAIGN

place label here

Name: _____
 UIN: _____
 Date: _____

Allergy Injection Therapy Orders

Please complete orders for the following vials:

Vial #	Contents	Strength	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: _____

Maintenance Schedule: _____

Adjustment for Missed Injections: _____

Series: _____

Maintenance: _____

Instructions for Local Reactions: _____

Instructions for Systemic Reactions: _____

Physician Name (printed)	Office Phone	Office Fax
Office Address Street	City	Zip Code

Physician Signature _____ **Date** _____
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Reviewed by _____ Date _____