PURDUE UNIVERSITY | Student Health Services

601 Stadium Mall Dr.
West Lafayette, IN 47907
Ph: 765-494-1818
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REFERRING ALLERGIST AGREEMENT (FIRST TIME)

My patient (listed below) is requesting Purdue University Student Health (PUSH) administer allergy extracts provided by my office:

Patient Name_____ Date of Birth_____

I agree to the following:

- I understand for my patient's safety and to facilitate the transfer of allergy treatment to our clinic, the PUSH specific **Allergen Immunotherapy Order Form** must be completed to provide standardization and prevent errors. Failure to complete this form **will delay or prevent** my patient from utilizing PUSH services. Complete and timely information will help us avoid delays in your patient's allergy extract administration. **The nurses will not proceed with scheduled injections until updated instructions have been received in the appropriate manner.**
- I will provide detailed directions regarding dosage/schedule adjustments that might be necessary due to patient missing scheduled injections or due to local systemic reactions by completing **Allergen Immunotherapy Order Form** provided by PUSH
- I will provide allergen immunotherapy extract in adequately labeled vials for administration at PUSH which will include: **Patient name, date of birth, contents of vial, dilution, and expiration date.**
- PUSH does not accept hand-carried medications and I agree to ship my patient's allergy extract from a Medical Provider's office. All allergy extract will be shipped on Monday, Tuesday and Wednesday utilizing FedEx next day delivery with tracking number.
- I will continue to be responsible for the management of this patient's immunotherapy and for the modification of doses during therapy. *If my office has multiple locations, it is my responsibility to provide the phone and fax numbers to the location that the patient receives their allergy injections.*
- I understand PUSH requires a 30-minute post-injection observation after each allergy injection. I understand that if my patient fails to comply with this requirement it could lead to their dismissal from receiving allergy injections at PUSH.
- If a patient fails to appear for injections for more than 90 days, the vials will be placed on hold and either returned to the prescribing allergist or discarded. Your office will be notified regarding patient failure to show. Expired extract will be discarded.
- I understand that the PUSH health care team does not take verbal orders for any dose changes regarding missed injection and that written instructions are required and to be faxed to (765) 496-3205 utilizing the PUSH **Allergen Immunotherapy Order Form**. I understand that PUSH will attempt to fax for new/updated orders 2 business days apart.
- Our physicians are qualified to supervise allergy injections given on a schedule as determined by your office. However, we are not allergy physicians. As a result, all allergy testing, mixing of extracts, allergy shot instruction, and the very first allergy shot MUST be done by your office.

- I understand that PUSH has EpiPen available to be used in case of a reaction. I also understand it is my responsibility as a prescribing provider to ensure my patient has their own EpiPen and instructions on its usage. If I order pre-administration requirements such as antihistamine or peak flow meter assessment, I will notify my patient of these expectations. PUSH **does not** provide peak flow meters and the patient will need to bring their own to each appointment, if applicable. Antihistamines will not be provided at the appointment, it is the responsibility of the patient to take prior to arriving for their appointment. Any prescriptions can be sent to Purdue Pharmacy, phone (765)494-1374, fax (765) 496-6094, or a pharmacy of their choice.
- Students that experience severe reactions will be evaluated and treated by a PUSH physician and may include a transfer to a local emergency facility. Your office will be notified of any emergent event.

Allergist
Signature_____Date_____

PUSH will accept the following legal signatures
Hand-signed (wet signature)
Provider's unique signature stamp
Time stamped and validated electronic signature

Please fax completed forms to (765) 496-3205.

This agreement is valid for the entirety of your patient's college career at Purdue University