OKLAHOMA INSTITUTE of ALLERGY ASTHMA & IMMUNOLOGY

Amy L. Darter, M.D. FACAAI, FAAAAI Jason M. Bellak, M.D.

1810 East Memorial Road, Oklahoma City, OK 73131
(P) 405.607.4333 (F) 405.607.4404 www.okallergy.com

Request for Administration of Immunotherapy
At an Outside Medical Facility

Please complete this form if the allergy injections will be administered at a facility other than the office of Amy L. Darter, M.D.

I have read and signed the **"Consent for Administration of Immunotherapy/Allergy Injections"**. However, I wish to have my injections administered at another medical facility (designated below), and I request Dr. Darter/Dr. Bellak to transfer my vaccine vial(s), along with instructions for administration of the injections, to the designated physician/facility. I understand that Dr. Darter has no legal or financial arrangement with the designated facility. I further understand that Dr. Darter/Dr.Bellak cannot assume responsibility for my medical treatment within the designated facility. I understand that it is my responsibility to make certain that the facility and its staff are willing and able to provide allergen immunotherapy, as well as the management of an immediate or delayed adverse reactions that may result from the immunotherapy. I agree that I will not attempt to administer my allergy injections to myself nor will I permit anyone who is not a licensed physician, or under the direct supervision of a licensed physician, to administer the injections. I further agree to notify Dr. Darter/Dr. Bellak if I transfer my vaccine vial(s) to any physician/facility other than the one designated below. I understand that I may call OIAAI at any time if questions or problems develop and that I may also return at any time to OIAAI for continued administration of my injections. **I understand that OIAA will not be held responsible for any loss/damage of mailed serum.**

Financial arrangements for purchase of the vaccine vial(s) will be made through OIAAI. Financial arrangements for the administration of the allergy injections, as well as the treatment of adverse reactions to the injections, will be made with the facility where the injections are administered.

_____ _____

Printed name of Immunotherapy Patient Date of birth

_____ _____

Patient signature (or legal guardian/parent) Date signed

_____ _____

Witness Date signed

Transfer vaccine to:	**FOR OFFICE USE ONLY:**
Physician's Name: _____	**Confirmation**
Address: _____	**Transfer Agreement Record from:**
City/State/Zip: _____	**_____**
Tel: _____	**Date: _____**
Fax: _____	**Approved by: _____**
	Date: _____
	Date Extract Transferred: _____

Please fax this page back to 405-607-4404

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Urgent fax- PLEASE RESPOND

Date: _____

Fax: _____

Patient: _____

DOB: _____

Dear doctor:

Guidelines for the administration of subcutaneous immunotherapy allergy injection now recommends that the prescribing allergist when asked to forward patients extract vials to another physician's office administration, confirms that the designated physician is able and willing to administer the allergy injections. The above referenced patient has been evaluated in my clinic and has been prescribed allergen immunotherapy as a part of the treatment plan for an allergic respiratory disorder. The patient or parent/legal guardian has requested that I forward the allergen extract along with detailed treatment instructions to you for administration in your office.

Sincerely,

Amy L. Darter, M.D. / Jason M. Bellak

Acknowledgment

My signature below acknowledges that my staff and I will administer allergen subcutaneous immunotherapy injections for this patient in a supervised medical setting (immediate physician availability). Furthermore I acknowledge the following facts: one- that my staff and I are trained in the recognition and management of both local and systemic reactions to the allergen immunotherapy, two -that my staff and I understand that Dr. Darter/ Dr. Bellak and their staff will be available for phone consultation as needed but will not be responsible for the training and supervision of my office personnel for procedures performed within my office or for any quality control measures within my office, and three- that I understand that the patient may return to OIAAI at any time for continuation of immunotherapy, if so requested by myself or by the patient.

Acknowledge and agreed by:	Send extract vial(s) and instructions to (clinic address):
_____ _____ Physician's signature Date:	_____ _____ _____

Please fax this page back to 405-607-4404

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Anaphylaxis: Immediate Treatment (standing orders)

Supplies: Systemic reaction sheet, Nebulizer with Xopenex, Duoneb or Albuterol, Epinephrine, Liquid Zyrtec with medicine dropper, Solu-Medrol, oxygen with tubing, face mask or cannula for oxygen, blood pressure cuff, stethoscope.

Purpose: The following is an outline for the management of any anaphylactic reaction which may occur in the clinic. The early signs and symptoms of anaphylaxis may include any or all of the following:

(1) Urticaria (Hives)
(2) Dyspnea (Difficulty breathing)
(3) Cyanosis (blueness of the skin or flushing/red skin)
(4) Pruritus (itching--anywhere on the body)
(5) Chest tightness/pain
(6) Rapid, weak pulse
(7) Diaphoresis (sweating)
(8) Seizure- like activity or loss of consciousness
(9) Decreased blood pressure
(10) Abdominal pain/cramping/nausea/emesis

Protocol (Standing Orders):

1) Notify all office personnel that an emergency is in progress. All emergency activities will take precedence over other "normal" office activities. Be care ***not to alarm other patients*** who may be in the clinic at the time of the emergency.
2) Have the patient sit or lay down in the designated Emergency Treatment Room
3) Check breathing rate, pulse, and blood pressure. If the pulse is slow and strong, call the physician before giving epinephrine. Record vital signs and observations every 5-10 minutes during the entire course of treatment for the suspected anaphylactic reaction.
4) Administer Zyrtec liquid orally:
    1. Adults and children >12 years of age: 15mg (3tsp)
    2. Children <12 years of age: 10mg (2tsp)
5) If indicated, proceed with epinephrine, given IM in the thigh. If there is any doubt about the need for epinephrine, GIVE IT
    1. Adults: inject 0.30mL of aqueous 1:1000 epinephrine (1mg/ml) IM
    2. Children: inject 0.15mL of aqueous epinephrine IM according to the child weight (estimate 0.01cc/kg for small children)
        1. 10kg= 22lbs =0.10cc
        2. 20kg= 44lbs =0.20cc
        3. 30kg= 66lbs =0.30cc
6) Apply a tourniquet above the injection site of the offending agent. Loosen the tourniquet q3 minutes.
7) Maintain an open airway and administer oxygen/breathing treatments (Duoneb, Xopenex, or Albuterol) if respiratory distress is present (O2 sats below 96%)
8) Call the physician STAT/Call 911 if situation warrants
9) Record all vital signs, observations, and medical treatment or the EMERGENCY TREATMENT RECORD
10) The physician will direct any additional medical measures beyond what is outlined above

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Anaphylaxis: Recognition and Management Guidelines (Treatment)

IMMEDIATE MEASURES:

A: Assessment of airway, breathing, circulation, and adequacy of mentation
B: Aqueous epinephrine 1:1000, 0.15-0.30cc (0.10cc/kg in children, max 0.30cc/dose) IM
Repeat as necessary every 5-20minutes (x3) to control symptoms and sustain blood pressure (1cc=1mL)

GENERAL MEASURES:

A: Place subject in recumbent position and elevate lower extremities
B: CALL 911 FIRST. Establish and maintain airway (endotracheal tube or cricothyrotomy may be required)
C: Administer oxygen/breathing treatment (Xopenex, Duoneb, or Albuterol)
D: CALL 911 FIRST. Normal saline IV for fluid replacement and venous access. IF severe hypotension exists, rapid infusion of volume expanders may be necessary (colloid-containing solutions)
E: Place a venous tourniquet above the injection site to decrease absorption of the injected antigen. Considering injecting 1/2 dose of epinephrine 1:1000 into allergen injection site

SPECIFIC MEASURES THAT DEPEND ON CLINICAL SCENARIO:

CALL 911 PRIOR TO ALL OF THIS!
A: Aqueous epinephrine 1:10,000 for intravenous infusion
B: If hypotension persists, dopamine, 200mg in 250mL D5W, should be administered IV at 2-20mcg/kg/min with the rate titrated to maintain blood pressure
C: Glucagon, administer using dosing instructions from vial
D: Glucocorticosteriods, such as methylprednisolone 1-2mg/kg/ q6h for 24 hours, are usually not helpful acutely but may prevent prolonged reactions or relapses
E: Hemodynamic and cardiac monitoring
F: Hospitalization (Patients demonstrating alterations in vital signs after 1-2 doses of epinephrine should be observed for a minimum of 12 hours after the reaction. Admission to the hospital under "24 hour observation" is an appropriate measure.)

KEY ADDITIONAL INTERVENTIONS FOR CARDIOPULMONARY ARREST OCCURRING DURING ANAPHYLAXIS:

A: High-dose epinephrine IV (i.e. Rapid progression to high dose)
B: Rapid volume expansion mandatory
C: Atropine and trans-cutaneous pacing if asystole/pulseless electrical activity (PEA) are present
D: Prolonged resuscitation efforts, as necessary

Name:	DOB:	Date:
Time of Allergen Exposure:	Dilution Dose:	
Provider:	Therapy: Slow/Regular Cluster # _____ or Conventional Aggressive or Slow	

Anaphylaxis: Emergency Treatment Record

Time:	BP	P	RR	O2	OBSERVATIONS:	MEDICATION	DOSE	ROUTE	TIME	INTIALS

Next dose Post Systemic:

Comments:

Initials:	**Signature:**

O Alert in IMS initials of nurse who entered: _____

O Pt called Post Systemic at least 6-12 hours after reaction

Anaphylaxis Emergency Action Plan

Name: _____ Age: _____

Allergy to: _____

Asthma: Yes --high risk for severe reaction No

Other health problems besides anaphylaxis: _____

Current medications, if any: _____

Symptoms of anaphylaxis include:	
Mouth:	itching, swelling of lips, and or tongue
Throat:	itching, tightness/closure, hoarseness
Skin:	itching, hives, redness, swelling
Gastrointestinal:	vomiting, diarrhea, cramps
Lung*:	shortness of breath, cough, wheeze
Heart*:	weak pulse, dizziness, passing out
Only a few symptoms may be present. Severity of symptoms can change quickly. *Some symptoms can be life threatening! ACT FAST!	

What to do:

1) Inject epinephrine in thigh using (Check one)
EpiPen Adult EpiPen JR Auvi-Q Adult Auvi-Q JR

Important: Asthma puffers and antihistamines can't be depended on in anaphylaxis

2) Call 911 or rescue squad (before calling contacts)

3) Emergency Contacts

Emergency contact #1: _____

Home: _____

Work: _____

Cell: _____

Emergency contact #2: _____

Home: _____

Work: _____

Cell: _____

Emergency contact #3: _____

Home: _____

Work: _____

Cell: _____

Do not hesitate to give Epinephrine

Comments: _____

_____ _____

Physicians Signature Date

_____ _____

Patient/Parent Signature Date

Injection Room Protocol

Before ***every*** injection, the nurse should ask the patient the following questions:

What antihistamine did you take?
Was it taken at least an hour ago?
Have you had any recent/current illnesses (i.e. wheezing, fever, acute illness?)
    *If so what?
Are you taking any new medications?
    *If so what?
Are you taking a Beta Blocker (Blood pressure medication?)
Do you have your EpiPen/Auvi-Q?

The patient must be able to tell you the name of the antihistamine they took; if they cannot give you the name of the antihistamine then **DO NOT** administer their injection until they can.

If the patient is asthmatic and has been ill within the last week previous to their injection (i.e. sinus infection, upper respiratory infection, fever, cold, cough, wheezing) they will need to check their peak flows prior to receiving their injection. If they are in the yellow zone, please ask them to return for their injection when they are feeling better.

All patients are required to wait a minimum of **30 minutes** after receiving their allergy injection(s)

All patients are **required** to show you their EpiPen/Auvi-Q. Any patient who does not have their EpiPen/Auvi-Q cannot receive their injection and must return at a later time with it.

Nurses: If you have any questions or concerns at all, please contact our office at **405-607-4333**. An inappropriate dose or mistake could result in life threatening episode of anaphylaxis. If an anaphylaxis reaction occurs: administer 0.01mg/kg of Epinephrine intramuscular (thigh) and contact our office immediately after patient is stable.

Beta (B) Blocker Consent

Consent to Receive Allergen Immunotherapy Treatment while taking Adrenergic Blocking Agents (Beta (B) Blockers).
Patients taking adrenergic blocking agents (Beta (B) Blockers) **may** be at an increased risk when receiving allergen immunotherapy because receptor blockade can make treatment of anaphylaxis (Severe Allergic Reaction) more difficult. Therefore, adrenergic blocking agents are **relatively contraindicated** for Immunotherapy according to the Immunotherapy Practice Parameters.

A List of Beta Blockers	
Brand Name:	**Generic:**
Betapace	Sotalol
Blocadren	Timolol
Bystolic	
Cartrol	Certeolol
Coreg	Carvedilol
Corgard	Nadolol
Corzide	Nadolol/Bendroflunetazide
Inderal	Propanolol
Inderide	Propanolol/ HCTZ
Kerlone	Betaxolol
Levatol	Penbutolol
Lopressor	Metoprolol
Normodyne	Labetalol
Sectral	Acebutolol
Tenoretic	Atenolol/HCTZ
Tenormin	Atenolol
Timolide	Timolol/HCTZ
Toprol	Metoprolol
Trandate	Labetalol
Visken	Pindolol
Zebeta	Bisoprolol
Ziac	Bisoprolol/HCTZ
Eye Drops Containing Beta Blockers	
Brand Name:	**Generic:**
Betagan	Levobunolol
AK Beta	Levobunolol
Betoptic	Betaxolol
Optipranolol	Metipranolol
Ocupress	Carteolol
Timoptic	Timolol

Dr. Darter requires that any B-Blocker be discontinued for 36 hours prior to the allergy injection and not resumed until 6-12hours after the injection. I have read, understand, and will follow the requirements of Dr. Darter. All of my questions have been addressed and answered.

Patient Name: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Immunotherapy Dosage Adjustment Schedule

Missed Dose Adjustments: If a patient misses a scheduled injection, the next dose should be adjusted as below:

*****Dose adjustment is measured from the last dose given*****

On "Build up":

Days 3-14, Continue on Schedule
Days 15-28, Repeat Prior Dose
Days 29-35, Decrease dose by 50%
Days >35, Consult Physician

On Maintenance (1:1) Red Vial:

1 week Injection Frequency (Remixes/REO):

Days 3-14, Continue on Schedule
Days 15-28, Repeat Prior Dose
Days 29-35, Decrease Dose by 25%
Days >36, Consult Physician

2-Week, 3-Week, 4-Week Injection Frequency:

Days 7 to 30-42, Repeat Prior Dose
Days 43-56, Decrease Dose by 25%
Days >56, Consult Physician (An appointment will need to be made)

Frequency between shots can be anytime from 1-4 weeks depending on individual patient preference, symptoms or Physician's Orders. The longest duration between shots 4 weeks (28 days). At 30 days you are considered late for your allergy injection (Always better to come early than late).

If you are frequently or persistently late, OIAA reserves the right to sit down with you and discuss the need and importance for compliance (Following the rules set forth in your original consent form when allergy shots were started)—It is our obligation to you as your provider.

For your safety, if you are over 40 days past due for an allergy injection, have not been seen recently by a provider (according to Follow Up instructions on last visit) and no appointment has been scheduled to be seen, you will need to make an appointment to see a provider in order to restart immunotherapy (Allergy Shot

OKLAHOMA INSTITUTE of ALLERGY ASTHMA & IMMUNOLOGY

AUTHORIZATION TO REFILL/PREPARE ALLERGEN EXTRACT

1810 E. Memorial Rd.

Oklahoma City, OK 73131

P: 405-607-4333 F: 405-607-4404

Patient Name: _____ Date of Birth: _____

Address, City, State, Zip: _____

Phone Number: _____ Insurance Carrier: _____

Witness: _____

I hereby authorize the Oklahoma Institute of Allergy and Asthma (OIAA) to prepare allergen extract for allergy immunotherapy for patient listed above

- **I UNDERSTAND THAT OIAA REQUIRES PAYMENT OF SERUM PRIOR TO MIXING.**
- I understand that OIAA files charges with my insurance carrier and that I am responsible for payment of all charges not covered by my insurance.
- Extract that is mailed to a patient or facility administering the injections require postage payment in advance of shipment. **I understand that OIAA will not be held responsible for any loss/damage of mailed serum.**

Signature of Patient/Guardian: _____ Date: _____

Circle One: Patient to pick up serum Serum to be mailed Injections Administered at OIAA

Address if being mailed: _____

_____

***Attention providers administering injections outside of this office please fax injection records to 405-607-4404**

FOR OFFICE USE ONLY

For refills only: please mail or fax the following form to OIAA when your vial is half empty

Out of serum refill concentrate (within 3-5 yrs. of treatment period)

Patient behind (illness, noncompliance, uncontrolled asthma, etc.)

Make new dilution: 1:10 1:100 1:1000

New skin test/new sensitivities/patient clinically not controlled (asthma or allergy)/revised extract order

Number of vials: 1 2 3 10cc vials 5cc vials

Rush Set: 5 dilutions _____ number of doses

Slow or Regular Cluster Set: 5 dilutions

Last SPT: _____ **Date Remixed**: _____ **Staff Initials**: _____

Dear Nursing Staff:

_____ has indicated a desire to receive allergy injections at your office. Instructions for your personnel are as follows:

1. Storage of Extract: Allergy extracts should be kept refrigerated. Avoid extreme heat or freezing.

2. Physician coverage: A physician MUST be in attendance at all times when injections are administered to provide medical emergency treatment if necessary.

3. Identification of patient: The patient should be correctly identified prior to the injection by confirmation of first and last name and date of birth. Patients should visually inspect their own vial(s) for identification purposes before receiving an injection.

4. How to administer: Use sterile precautions when administering the injection. Use a 1cc allergy syringe with a 1/2 inch 26-27 gauge needle. The injection should be administered subcutaneously, after slight retraction of the plunger (to avoid intravenous administration) in the lateral aspect of the upper arm. If blood appears with retraction of the plunger, remove immediately and repeat the procedure. The normal injection angle is 90 degrees. As the needle is removed, press the injection site to prevent leakage through the needle tract. Do not massage the area. MAKE SURE THE PATIENT HAS TAKEN AN ANTIHISTAMINE PRIOR TO THE INJECTION.

5. DOSAGE AND DOCUMENTATION: Record, date, dilution, dosage, injection site (Left, Right, or both arms), peak flow (if applies to patient), reaction (if any), administering nurses initials, antihistamine taken, and EpiPen/Auvi-Q expiration date. Patients on build-up will begin injections at the most diluted concentration and progress to the next higher concentration after receiving the scheduled doses and tolerating those well. Patients should fill out Extract Remix Authorization consent that is attached in this Off Campus packet, then it should be faxed back to OIAA at **405-607-4404**, when vials are LOW not EMPTY. There is a two week turnaround time on mixing and mailing serum. For timely return please do not wait until vials are empty.

6. WHEN TO ADMINISTER: Injections may be administered 1-2 times weekly, allowing at least 72 hours between injections until the patient reaches their target dose. At the target dose, the patient should NOT receive injections more frequently than once a week (7 days). At that time they may spread their injections if they choose as follows:

(Once target dose is given, injections are given every 2 weeks for three visits, then every 3 weeks for three visits and then every 4 weeks.) An injection 1-4 weeks is acceptable based on patient preference.

7. WHEN NOT TO ADMINISTER AN INJECTION: Patients should not receive injections if they have a fever >100 degrees, cough, increased asthma symptoms, or if they have received an immunization within the last 24 hours. **(Except for the flu vaccine, which can be administered on the same day)**

8. OBSERVATIONS: Patient must remain in the office for 30 minutes after receiving their injection(s). Injection site must be inspected prior to patient's departure from the clinic.

Patient Name: ____________________________ **DOB:** ______________________

Date	Dilution/ Dose (i.e. Blue Red Gold)	Name of Antihistamine (Pre-Med)	Systemic Reaction/ Large Local?	Injection Site Location?	Epipen/ Auvi-Q Present/not expired?	Any new medications/new illness?	D/C Beta Blockers? (36 hrs. prior) If applicable	Initials
					Yes/No	Yes/No	Yes/No	
					Yes/No	Yes/No	Yes/No	
					Yes/No	Yes/No	Yes/No	
					Yes/No	Yes/No	Yes/No	
					Yes/No	Yes/No	Yes/No	
					Yes/No	Yes/No	Yes/No	
					Yes/No	Yes/No	Yes/No	
					Yes/No	Yes/No	Yes/No	
					Yes/No	Yes/No	Yes/No	
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					Yes/No	Yes/No	Yes/No	
					Yes/No	Yes/No	Yes/No	
					Yes/No	Yes/No	Yes/No	
					Yes/No	Yes/No	Yes/No	
					Yes/No	Yes/No	Yes/No	
					Yes/No	Yes/No	Yes/No	
					Yes/No	Yes/No	Yes/No	
					Yes/No	Yes/No	Yes/No	
					Yes/No	Yes/No	Yes/No	

Record Sheet for Allergy Injections

Anaphylaxis: Recognition & Management Guidelines (Signs & Symptoms)

Every member of the office staff, including physicians, nurses, technicians, and physician surrogates, and front office personnel, should be familiar with these signs and symptoms of an anaphylactic reaction. (It is often the staff in closest contact with the waiting room that will see the early signs of a systemic reaction)

System:	Reaction:	Symptoms:	Signs:
Respiratory:	Rhinitis	nasal congestion, itching, sneezing, clear rhinorrhea	mucosal edema
	Laryngeal Edema	dyspnea, hoarseness, dysphasia, stridor, "lump in throat"	glottis edema, cyanosis
	Bronchospasm	cough, dyspnea, chest tightness	cough, wheezing, tachycardia, retractions
Cardiovascular:	Hypotension	lightheadedness, syncope, "sense of impending doom"	hypotension, tachycardia, cold, clammy
	Arrhythmia	palpitations, syncope	irregular rate, rhythm
	Cardiac Arrest	LOC/COMA, apnea	absent pulse
Skin:	Urticaria	pruritus, flushing	wheal and flare
	Angioedema	swelling	skin/structure edema
Gastrointestinal:	Bowell Wall Edema	nausea/vomiting, abdominal cramping, diarrhea	loose stools (may be bloody)
Ocular:	Conjunctivitis	ocular itching, lacrimation	conjunctival injection/edema, tearing, itching
Miscellaneous:	Uterine Contractions	cramping	
	Bladder Contractions	urgency/loss of control	