USC Engemann
Student Health Center

Allergy/Immunization Clinic

Allergy Desensitization Injection Program

Dear Doctor,

Your patient is requesting transfer and continuation of his/her allergy desensitization injection program to the Engemann Student Health Center while he/she attends the University of Southern California (USC).

The program is managed under the supervision of our Consulting Allergist. Our goal is to maintain an allergy desensitization program for students who are in a continuing program through their private allergist.

Our intent is to follow the prescribing physician's orders and schedule to the extent that they fall within our guidelines. These guidelines will take precedence if any aspect of the student's desensitization program is ambiguous or in conflict with our procedures and policies.

Please submit:

- ☐ 1. A Full Build Schedule showing Starting Dose through Maintenance Dose
- ☐ 2. Missed Dose Adjustment Protocol for both Building and Maintenance Schedules
- ☐ 3. Injection Record over past 3-6 months
- ☐ 4. Completed attached form titled "Onset of Immunotherapy"

Note: Any missing information may lead to a delay in injection administration.

All antigen vials must have the following information printed legibly on their labels:

1. Patient's name & DOB
2. Expiration date
3. Dilution or concentration (e.g., 1:1000, 500 BAU, etc.)
4. Physician's name
5. Contents (i.e., tree mix, environmentals, etc.)

After receiving the above information, an appointment will be made for the student to be evaluated by our Consulting Allergist.

Thank you for assisting us in providing continuity of care to our mutual patient.

Engemann Student Health Center · 1031 W. 34th St · Rm 145 · Los Angeles, CA 90089
Tel: (213) 740-9355 Fax: (213) 821-2740

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Patient Label

Allergy/Immunization Clinic

Onset of Immunotherapy

Name:	
USC ID #:	Date of Birth: (MM/DD/YY)

Patient Information

1. Has your patient exhibited systemic reactions on the present treatment program? ☐Yes ☐No
   If yes, please describe:

   _____

2. Is Patient on a beta-blocker?
   ☐Yes ☐No

3. Please List all medications:

   _____

4. Additional Information and/or special instructions:

   _____

Office Contact

Name:	Best time to be reached:
Telephone #:	Physician Telephone:
Physician's Name: (please print)	Physician Fax:
Office Address:	
Physician Signature:	Date: (MM/DD/YY)

Please Note:
We will not be able to administer allergy shots to your patient unless all of the above information is completed in full and signed by the physician. Thank you.

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