SOUTHERN ILLINOIS UNIVERSITY EDWARDSVILLE

SIUE HEALTH SERVICE
0222 STUDENT SUCCESS CENTER
EDWARDSVILLE, IL 62026-1055
TELEPHONE: 618-650-2842
FAX: 866-579-9876

Dear Provider,

The Southern Illinois University Edwardsville Health Service's goal is to provide care needed by our patients in the safest way possible. Your assistance with this goal is not only required but also greatly appreciated. To maximize the safety margin for the patients, our clinic utilizes a Therapeutic Injection Order form for every patient requesting this service in our clinic.
In order for student patients to receive therapeutic injections at the SIUE Health Service clinic, we **require** the following:

1) Every student patient's initial injection(s) must be performed at the ordering provider's office.
2) We will not mix or dilute any extracts; this must be done by the prescribing provider. We will store only allergy extracts in the clinic.
3) Each vial/medication must be clearly labeled with:
    a. Patient's name
    b. Name of the antigen(s)
    c. Dilution
    d. Expiration date
4) Instructions must include contents of the serum/injection, concentration of the serum, dose/strength, frequency of the injection, early/ late injection guidelines, expiration date, graduation of increase in dosage (if applicable), and adverse reaction management. This is required with each new vial, even if the vial contains the same serum in the same concentration.
5) **The Southern Illinois University Edwardsville Health Service Therapeutic Injection order form AND medical records MUST be completed and provided to the SIUE HS clinic prior to a student patient receiving injections.**

Please note that our role in this process is limited to the administration of the injection according to the instructions provided. We will not be responsible for the management of the patient's ongoing care, follow-up, or any related issues that may arise after the procedure. Any additional patient management or follow-up should be conducted by your office.

Please find attached the SIUE Therapeutic Injection order form required for this procedure. Should there be any further details or adjustments needed, please do not hesitate to contact us.

Sincerely,

SIUE Health Care Team

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Patient: Last Name ______________ **First Name** ______________ **SIUE ID #** ______________

Please complete Allergy Injection orders for the following vials:

Injections will not be given until this form AND medical records have been received by our office. (please do not say "see attached") Send your treatment record and the patient's serum along with this form (unless we have it already).

Vial #	Contents	Strength	Frequency	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 – include minimum/maximum day range: ________________________________

Maintenance Schedule – include minimum/maximum day range: ________________________________

Adjustment for Missed and/or Off-schedule Injections: ________________________________

Instructions for Local Reactions:________________________________

Instructions for Systemic Reactions:________________________________

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

Office Hours of Operation:

Physician Signature________________________________**Date**________________

Reviewed by________________________________Date________________