University of Colorado Boulder
Wardenburg Medical Services
Allergy Clinic
1900 Wardenburg Drive
UCB 119
Boulder, CO 80309-0119
Phone 303-492-2057 Fax 303-492-6850

Patient Summary and Checklist

Patient Name:	DOB:
Facility/Allergist Name:	Location:
Phone:	Fax:
Antigen Mixing Lab (if different)	Due date of: Last eval: Next eval due:
Dx Indicating IT:	Hx of Asthma? None Mild Intermittent Persistent
PT or ACT needed prior to IT admin? Yes No	Minimum PF or ACT Value to admin IT:
Hx of systemic rx to IT shots? Yes No	Antihistamine Prior to shot: Yes No
Build Interval:	**Maintenance Interval:**
Date Maintenance dose achieved:	**Maintenance (top) dose: Dilution: Vol:**
Alerts and/or Special Instructions:	

THIS FORM IS TO BE FILLED OUT AND COMPLETED BY ALLERGIST'S OFFICE AND FAXED TO 303-492-6850

WE DO NOT INTIATE SHOTS. FIRST SHOT MUST BE DONE IN YOUR OFFICE.

- COMPLETE ABOVE CHART (We are working with dozens of offices across the county and need a standardized summary sheet)
- Fax a copy of the most recent MEDICAL EVALUATION relevant to IT
- Fax a copy of the current orders for IT to be completed at our clinic
- Fax a copy of the recent INJECTION RECORD, noting reactions and dose
  - ❖ PLEASE INDICATE DOSE/WHERE OUT CLINIC SHOULD START
- Fax LATE DOSE INSTRUCTIONS for building and maintenance phase
- Send VIALS to above listed address. Wach vial must be labeled with:
  a. Patient name
  b. Contents
  c. Dilution
  d. Expiration date

SHIPPING AND RECEIVING HOURS OF OPERATION: MON-FRI 8AM-4PM. WE ARE CLOSED WEEKENDS AND HOLIDAYS