(Sticker)
Name: ____________________

I.D. # :______________DOB:______________

Telephone:______________Date: ______________

Wardenburg Health Services
Allergy Clinic

Date:_______

Request for Allergy Information

Your patient,________________________DOB_______, a student at the University of Colorado Boulder, has requested that Wardenburg Health Services administer his/her allergy injections while on campus. **We do not begin immunotherapy. Please arrange to give initial shots in your office.**

In order for Allergy Clinic staff to assure temporary medical management responsibility for your patient, we will need **ALL** of the following information from you before we can administer allergy injections:

1) **A copy of the recent Medical Evaluation for Immunotherapy including the following:**
   a) **Indications for immunotherapy**
   b) **Documentation of persistent or intermittent asthma (if applicable)**
      i) **Documentation of whether pre and or post PFs should be done**
   c) **Other medical diagnoses (if applicable)**

2) **A copy of the patient's injection records, noting reactions**

3) **The patient's immunotherapy schedule detailing the following:**
   a) **starting immunotherapy dose/ where we should start**
   b) **target maintenance dose**
   c) **immunotherapy build-up schedule**
   d) **instructions for late injections during the build-up phase**
   e) **instructions for late injections during the maintenance phase**
   f) **instructions for localized reactions**

4) **Each vial must be labeled with the following:**
   a) **patient's name**
   b) **contents**
   c) **the dilution**
   d) **the expiration date**

Please send **VIALS** and information to:

University of Colorado
Wardenburg Health Services Attn: Allergy Clinic
1900 Wardenburg Dr.
Boulder, CO 80309-0119
Phone: 303-492-2057 **FAX: 303-492-6850**

Thank you for your cooperation.
Sincerely,
Julie Jacobson-Weaver, MS, FNP-BC, Allergy Clinic Oversight Provider