ILLINOIS
McKinley Health Center

place label here

Name:

UIN:

Date:

Allergy Injection Therapy Orders

Please complete orders for the following vials: ****Referring allergist MUST complete this section**

Vial #	Contents	Strength	Frequency	Expiration Date	Date of Last Injection

- Please tell us the minimum number of days permissible between shots.
  (If not specified we follow a 48 hour minimum interval between shots) _____
- Adjustment for Missed Injections:_____
- Building (Series) Adjustments:_____
- Maintenance Adjustments:_____
- Special Instructions (ex. Peak flow, blood pressure with parameters):_____

***Allergy patients have a 30 minute wait time. If you request longer, please specify.**

Office Name/Board Certified Allergist name (printed)	Office Phone	Office Fax

Office Street	City, State	Zip Code

Please give us your office hours when we may call with questions or therapy issues: (If multiple offices, indicate location where patient is seen)

Physician Signature_____**Date**_____

***your signature confirms orders are under a Board Certified Allergist**

Vials must be received from allergist via commercial Carrier:
Immunization & Travel Clinic
McKinley Health Center
1109 So. Lincoln Ave.
Urbana, IL 61801
Hours: Monday-Friday 8:00 a.m. to 5:00 p.m.
Phone (217) 333-2702 • Fax (217) 244-3067

Reviewed by_____Date_____

***Bolded framed sections must be completed in order for patient to receive allergy injections at McKinley Health Center**