

MANHATTAN COLLEGE
HEALTH SERVICES
Alumni Hall, Suite 104
Riverdale, New York 10471
Phone (718) 862-7217 Fax (718) 862-7797

Patient's Name: _____ Birth date: _____

Date: _____

Dear Doctor:

Your patient plans to receive allergy injections at Manhattan College Health Services. In order for the injections to be administered here, the following information must be submitted with the vials so that we may give care to your patient:

- _____ 1. Patient's first and last given name
- _____ 2. Date, content and dose of the last injections(s) given by your office
- _____ 3. Your printed name, address, phone and fax numbers
- _____ 4. Contents of antigen vials with corresponding vial identification
- _____ 5. Administration intervals
- _____ 6. Dosage and increments as applicable
- _____ 7. Late instructions if interval not adhered to by patient
- _____ 8. Treatment of reactions and dosage adjustment post-reaction
- _____ 9. Any special instructions
- _____ 10. Your required interval after administration if it is longer than the 20 minutes which we require of all patients receiving antigen therapy. In case of bee venom or other insect antigen therapy we observe patients for 30 minutes.
- _____ 11. We request on each vial the following:
 - a. Patient's first and last given name or identification number
 - b. Vial identification of antigen contents indicated on written schedule and on vial
 - c. Expiration date
- _____ 12. PHYSICIANS HANDWRITTEN SIGNATURE ON EACH NEW SUPPLY OF ANTIGEN AND/OR NEW ADMINISTRATION SCHEDULE SUBMITTED (OTHER'S SIGNATURES ARE NOT ACCEPTABLE)

Please have your patient bring the antigen vial(s) and schedules to the office listed above. If you have any questions please feel free to call. I appreciate your consideration in this matter.

Sincerely,

Katherine Kyle, NP