Belmont University Health Services
1900 Belmont Blvd, Mcwhorter Suite 106, Nashville TN 37212
Phone: (615) 460-5506 Fax: (615) 460-6131

The Belmont University Health Service's goal is to provide the care needed by our patients in the safest way possible. Your assistance with this goal is not only required, but also greatly appreciated.

Our clinic serves many patients referred by multiple allergy specialists. Each allergy specialist has a unique form that they use in their office. As you can imagine, utilizing multiple different forms is very challenging and has significant potential for error. Therefore, to maximize the safety margin for our patients, our clinic has developed an allergy immunotherapy administration form that we will utilize in the office for every patient.

For patients to receive allergy immunotherapy at BUHS, we require the following:

1. Patient's initial injection(s) must be performed by Allergist's office
2. We will not mix or dilute any extracts; this must be done by the prescribing allergist. Allergists may send serum to Belmont Health Services or students may bring serum to clinic if Allergist allows. Vials will be stored at 2-8 C (35-46 F).
3. Each vial must be clearly labeled with:
    a. Patient's name
    b. Name of the antigen(s)
    c. Dilution
    d. Expiration date
4. The BUHS Immunotherapy Administration form MUST be completed in its entirety and returned to our clinic prior to a patient receiving injections. (Example of incomplete form: writing "see attached/included instructions")
5. There is a charge associated with injections. While we do not participate in or bill any insurance plans, we can provide receipts for the patient to submit to insurance companies for reimbursement.

Please visit our website at https://www.belmont.edu/health-services/index.html for more information. These requirements are purely for the safety of our patients. Failure to comply with these requirements could delay and potentially prevent utilization of our services.

Thank you,

Belmont University Health Services
1900 Belmont Blvd, Mcwhorter Suite 106
Nashville TN 37212

Continue to page 2 for the Allergy Immunotherapy Consent Form

We are staffed with a nurse practitioner at all times that allergy injections are given. We have the following available to treat potential reactions to an injection:

- Oxygen
- Epinephrine
- Benadryl
- Albuterol Nebulization
- IV fluids

All patients are required to wait a minimum of 20 minutes after injection unless otherwise ordered.
Allergy serum may be sent with the patient or mailed to:

Attention: Health Services
Belmont University
1900 Belmont Boulevard
McWhorter Suite 106
Nashville, TN 37212

*Please specify on package that allergy vials are enclosed and indicate refrigeration needed. *

IN ADDITION TO the Immunotherapy Administration Form, please attach current shot record as well as adjustment instructions for missed injection and reactions.

We will fax shot records and refill requests as needed.

If you agree to these conditions, please sign permission below.

Provider Address _____
_____
_____

Provider Phone: _____ Fax:_____

I give my permission for _____ to receive allergy
(Pt name and DOB) injections at Belmont University Health Services.

Provider Name _____
(Printed)

Provider Signature _____ Date_____

Continue to page 3 for the Allergy Immunotherapy Administration Form

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Allergy Immunotherapy Administration Form

To transfer allergy treatment to our clinic, this form **MUST** be completed. **Failure to complete this form entirely will delay or prevent the patient from utilizing our services.** Form can be delivered by the patient, mailed, or faxed.

Patient Name: _____ DOB: _____

Physician: _____Office Phone: _____ Fax: _____

Office Address: _____

Is Peak Flow Required Prior to Injection?	**YES** **NO** If yes, it must be > L/min to proceed
Antihistamine Required Prior to Injection?	**YES** **NO**
Patient Required to Carry EpiPen?	**YES** **NO**
Patient Wait Time Post Injection?	_____ minutes
How long can vials remain unrefrigerated?	
Minimum wait time between allergy injections and other injections (immunizations, TB skin test, etc.)	
Patient Allowed to Transport Own Vials?	**YES** **NO**
Rotate arms for allergy injections?	**YES** **NO**

Allergy Vials

Minimum time between allergy inj.:					
Dilution:					
Vial Cap Color:					
Expiration Date:	___/___/____	___/___/____	___/___/____	___/___/____	___/___/____

Management of Missed Injections (according to number of days from ***LAST*** injection)

During Build-Up Phase	During Maintenance Phase
___ to ___ days – continue as scheduled	___ to ___ days – continue as scheduled
___ to ___ days – repeat previous dose	___ to ___ days – repeat previous dose
___ to ___ days – reduce previous dose by ___ mL	___ to ___ days – reduce previous dose by ___ mL
___ to ___ days – reduce previous dose by ___ mL	___ to ___ days – reduce previous dose by ___ mL
Over ___ days – contact office for instructions	Over ___ days – contact office for instructions

Reactions:

Repeat Dose if swelling is < _____mm or >_____ mm

Reduce Dose by one increment if swelling is > _____mm

Additional Instructions: _____

Physician Signature: _____ Date: _____

Revised Aug 2024

Belmont University Health Services

Allergy Patient Informed Consent and Policy Agreement Form

Belmont University Health Services provides immunotherapy injections for all currently enrolled students, staff, and faculty. Our Health Services clinic is staffed by board-certified nurse practitioners that are always present during allergy injection administration.

Fees for injections will be collected at **EACH VISIT** as we do not bill insurance. You can check our website for forms of payment accepted. We currently charge an administration fee **per allergy injection**. This may be subject to change.

You **MUST** have a scheduled appointment time for injections to be given. You **MUST** be seen for an "Allergy Consult" in our clinic prior to starting allergy injections with us. Your allergist is responsible for starting your immunotherapy before transferring administration to our clinic.

A nurse will follow your physician's instructions for administering allergy injections. If the instructions are unclear, or if you are late for your injections, your physician will be contacted. It is your physician's responsibility to explain the risks of receiving allergy injections. You will be required to sign this form to receive allergy services at Belmont University Health Services.

The duration of your therapy should be determined by your allergist. It is recommended that you have annual visits with your allergist to assess your immunotherapy.

You must report to the nurse any current illness or any prescription or non-prescription medications you are currently taking prior to the receipt of an injection. **WARNING**: individuals who are using a class of medication called a beta blocker probably should not be on allergy injections. Examples of these drugs include Inderal, Lopressor, Tenormin, and Corgard, as well as others. Please let us know if you are taking any of these medications.

Reactions from receiving allergy injections may range from minor skin irritation and itching to difficulty breathing. You are required to wait the allotted time given by your allergist post injection. Nearly all serious reactions begin within 5-30 minutes after the injection is given. Inform the nurses immediately if you are experiencing **itching, hives, coughing, sneezing, tightness in chest or throat, wheezing, or difficulty breathing.** If you have any of these symptoms after your departure, you should return to Health Services or report to the nearest hospital emergency room for prompt treatment.

It is recommended that you do not perform any strenuous exercise for one hour before and one hour after an injection.

All reactions must be reported to the nurse before you receive your next injection. Local reactions consist of swelling and itching at the injection sire. Please measure the size of the swelling (not the area of redness) and record the length of time the swelling lasts.

If you discontinue treatment or fail to appear for treatment for a period of ninety days, your vial will be put on hold and may be sent back to your allergist or discarded.

PLEASE REVIEW THE STATEMENT AND SIGN/DATE BELOW

I have read or have had explained to me the information above. I have had the opportunity to discuss this information and agree to follow the instructions.

Patient's Signature: _____ Date: _____

Parent/Guardian Signature: _____Date: _____
(If patient is under the age of 18 years old)

Please return completed form to:
Belmont University Health Services
1900 Belmont Blvd, McWhorter Suite 106
Nashville, TN 37212

Revised May 2023