University of Colorado at Boulder
Wardenburg Health Services
Allergy Clinic
Boulder, CO 80309-0119
Phone: 303-492-2057 Fax: 303-492-6850

Patient Summary Sheet & Checklist

Patient Name:	DOB:
Facility/ Allergist Name:	Location:
Phone:	Fax:
Antigen Mixing Lab (if different than above)	Phone: Fax:
Date of last visit w ALLERGIST for eval:	Due date for next eval:
Diagnosis indicating IT:	Hx of Asthma? None: __Mild: __Intermittent: __Persistent__
PF or ACT needed prior to shot admin: Yes__ No__	Minimum PF or ACT Value needed administer IT:
Hx of systemic rx to allergy shots: Yes_____ No____	Antihistamine Prior to shot: Yes: _____ No: _____
Build interval:	**Maintenance interval:**
Date Maintenance Dose Achieved:	**Maintenance/top dose: Dilution_____ Volume _____**
Alerts/ Special Instructions:	

THIS FORM IS TO BE FILLED OUT AND COMPLETED BY ALLERGIST'S OFFICE

- COMPLETE CHART ABOVE (we are working with dozens of offices across the country and need a standardized summary sheet).
- Fax a copy of the most recent MEDICAL EVALUATION relevant to IT.
- Send a copy of the patient's INJECTION RECORD, noting reactions. **Circle starting dose/where our office should begin.**
- LATE INSTRUCTIONS for Building Phase AND Maintenance Phase
- Send VIALS to above listed address. Each vail must be labeled with…
  a. Patient Name
  b. Contents
  c. Dilution
  d. Expiration Date

  ***Shipping and Receiving Hour of Operation: M-F 8am-4pm, Closed Weekends & Holidays**

***WE DO NOT INITIATE IT. PLEASE ARRANGE TO GIVE INITIAL SHOTS AT YOUR CLINIC.**