Adelphi University

Health Services Center
Waldo Hall
Garden City, NY 11530
Phone (516) 877-6000 Fax (516) 877-6008

Patient's Name: _____ DOB: _____

Date: _____

Dear Doctor:

Your patient plans to receive allergy injections at Adelphi University's Health Center. 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 o004(c)n12.99800s-erap/1/998(an)4/svu

a. Patient's first and last given nam
b. Vial identification of antigen co
c. Expiration date.

_____12. PHYSICIANS HANDWRITTEN SIGNA
NEW ADMINISTRATION SCHEDULE
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 me. I appreciate your consideration in this matter.

Sincerely,

Jacqueline- R K Q V W R Q, MSN, NP-B
Director of Health Services