

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

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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 name
  - b. Vial identification of antigen component
  - c. Expiration date.
- \_\_\_\_\_ 12. PHYSICIANS HANDWRITTEN SIGNATURE AND DATE (NEW ADMINISTRATION SCHEDULE MUST BE 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