PHYSICIAN IMMUNOTHERAPY CHART

Patients Name: _____ DOB: _____

Diagnosis: _____ Phone #: _____

Prescribing Physician: _____ Address: _____

Telephone #: _____ Fax #: _____ Business days/hours: _____

Abbreviation: Tree: T Mold: M Grass: G Cat: C Dog: D Weed: W Ragweed: RW Cockroach: CR Dust Mite: DM Mixture: Mx

Alternate Arms: Yes/ No

		Vial # 1 Contents:_____ _____ Concentration:_____ Vial color:_____ Expiration date:_____				Vial # 2 Contents:_____ _____ Concentration:_____ Vial color:_____ Expiration date:_____				Vial # 3 Contents:_____ _____ Concentration:_____ Vial color:_____ Expiration date:_____				Peak Flow				
Date	Time In	R	L	VOL	Reaction	R	L	VOL	Reaction	R	L	VOL	Reaction	Pre	Post	Notes	Time out	Initial

Reviewed 5/2018