UNIVERSITY HEALTH CENTER
Leading the Way to Healthier Terps

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