UNIVERSITY HEALTH CENTER

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PHYSICIAN IMMUNOTHERAPY CHART

Patient 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

Dose #		Vial # 1 Contents_____ _____ Concentration:_____ Vial color: _____ Expiration date:_____				Vial # 2 Contents_____ _____ Concentration: _____ Vial color: _____ Expiration date: _____				Vial #3 Contents_____ _____ Concentration: _____ Vial color: _____ Expiration date: _____				Initials	
Date	**Time In**	**R**	**L**	**VOL**	**REACTION**	**R**	**L**	**VOL**	**REACTION**	**R**	**L**	**VOL**	**REACTION**		**Time Out**