Dear Doctor: If you are using this form for allergen immunotherapy, you must provide the information requested in blocks #1, 2, 3, 4, 5, 6, 7, 10, 11, and 12.

TO: FOH Occupational Health Center Patient

Name:_______________________________________
Diagnosis:____________________________________

Physician’s Orders (may attach additional page):

<table>
<thead>
<tr>
<th>1) Exact Name of Medication</th>
<th>2) Dosage</th>
<th>3) Interval of Administration</th>
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<tbody>
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</table>

4) Method of Administration:  _____ SQ    _____ IM

5) Expiration Date of Order:  (if less than 6 months)

6) First dose of each new multi-dose vial or box of single dose
   Should be given at:  _____ Prescribing physician’s office
   _____ FOH Occupational Health Center

7a) Side effects/reactions anticipated

7b) Should the patient develop a reaction, carry out the following orders:

8) Bedrest - Frequency and Duration (Please state reason on back of form. **Important:** Bedrest may not be available for more than 20 min/day).

9) Other treatments and/or instructions - Frequency and Duration (Blood pressure, soaks and packs, dressing, etc.)

10) Date Patient to return to my office:  11) Physician’s Telephone

12a) Physician’s Signature:  12b) Printed Name

13) Date:

All physician treatment orders expire in 6 months

Health Unit Address Stamp Here: