ALLERGY LABORATORIES, INC.
ESTABLISHED 1929

ALLERGY INJECTION ADMINISTRATION FORM

_____ _____

Patient Last, First Name Patient Date of Birth

Use CPT Code **95115** or **95117** and Diagnosis Code **477.9**

ALWAYS:

Verify patient name on each vial matches with the patient prior to injection..
Note that some patients may have more than one prescription vial and may require multiple shots.
Keep records of all patient injections from any of the patient's vials.

Assign symptom grade level of 0 to 5 (worst).

Vial 1 – Green, weakest dose (RAST -2)
Vial 2 – Blue, stronger (RAST -1)
Vial 3 – Gold, even stronger (RAST 0)
Vial 4 – Red, strongest (RAST +1)

DATE	HA	Nose				Eyes		Throat		Arm L - R	Vial A,B,C,D	Dose	Reaction and Notes	Init

Headache
Stuffy
Running
Post Nasal Drip
Sneezing
Itching
Watering
Throat Itch
Cough

ALLERGY INJECTION ADMINISTRATION FORM

Continued for Patient: ______________________________

	Headache	Stuffy	Running	Post Nasal Drip	Sneezing	Itching	Watering	Throat Itch	Cough					
DATE	HA	Nose				Eyes		Throat		Arm L - R	Vial A,B,C,D	Dose	Reaction and Notes	Init