



Allergy & Asthma Center

of Southern Oregon, PC

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Checklist and Approval for Remix of Allergy Serum

(Patient Name)

(Patient DOB)

(Patient ID#)

Date Remix Auth. Signed: _____

Date Patient Started Immunotherapy: _____

Steps 1-3 to be completed by Shot MA with patient:

1. Current Medication Use: (mark all)

- Medication use for optimal control discussed with patient
- Frequency of shots? Circle one: Q weekly Q 2 weeks Q monthly Other
- Which antihistamines are used on shot days? _____

2. Reactions to Injections: (mark one)

- No significant reactions
- Local reactions (dime sized swelling or larger) in the past month
- Systemic reactions (needed Epinephrine in the last year)
- Other: _____

3. Patient's Response to Immunotherapy: (mark all that apply)

- Much better- nose allergies- occasional antihistamines
- Much better- asthma symptoms 2 days weekly or less
- Much better- skin eczema rash infrequent (<1 time monthly)
- Allergy symptoms remain active
- Allergy symptoms unchanged
- Worst Seasonal Symptoms: Circle: Spring Summer Fall Winter

MD Steps 4-7 to be completed by AAC medical doctor overseeing immunotherapy:

4. Antigen Content of Vials: (mark all that apply)

- Antigen mix is still optimal for current medical status
- Antigen content of vials needs to be adjusted (optional)
- Other: _____

5. Injections are: (mark one)

- Continued as patient getting ongoing symptom improvement
- Patient okay to graduate (>4-5 years immunotherapy done)
- Patient needs long term immunotherapy (>5 years) marked ongoing symptoms and ongoing marked exposure
- Patient needs allergy reevaluation
- Other: _____

6. I have considered all of these in making the decision to continue immunotherapy.

7. Medical doctor overseeing patient needs to sign Remix Authorization Form on next page.

(Signature of Medical Doctor Overseeing Immunotherapy)

Dr. Kerwin / Dr. Parks / Dr. Israelsen

(Today's Date)