**When completing this form please refer to** **ASCIA Guidelines - Adrenaline (Epinephrine) Injector Prescription -** [**www.allergy.org.au/hp/anaphylaxis/adrenaline-injector-prescription**](http://www.allergy.org.au/hp/anaphylaxis/adrenaline-injector-prescription)

**PRESCRIBING DOCTOR DETAILS**

Doctor’s Name:

Practice Address:

Email: Phone:

Provider No: Date:

**PATIENT DETAILS**

Patient Name:

Date of Birth:

**CLINICAL DETAILS**

Date of last reaction:

Suspected allergen/s:

**Confirmed by:**

[ ]  Skin Testing

[ ]  Allergen Specific IgE blood tests

**Did the patient have a:**

[ ]  Severe allergic reaction (anaphylaxis)

[ ]  Generalised allergic reaction

**Modifying factors:**

[ ]  Asthma (current or past history)

[ ]  Adolescent or young adult

[ ]  Nut allergy (peanut or other nut)

[ ]  Stinging insect allergy (bee, wasp, jumper ant) if patient is an adult

[ ]  Co-morbid condition (such as ischaemic heart disease)

[ ]  Limited access to emergency medical care

**Other:**

[ ]  Patient has been given an ASCIA Action Plan for Anaphylaxis, with their adrenaline injector/s.

To access plans go to [**www.allergy.org.au/hp/anaphylaxis/ascia-action-plan-for-anaphylaxis**](http://www.allergy.org.au/hp/anaphylaxis/ascia-action-plan-for-anaphylaxis)

[ ]  Would you like this patient to be seen by the clinical immunology/allergy specialist? If yes, please provide a referral letter to the specialist with patient contact details, to arrange an appointment.

Comments:

**FOR COMPLETION BY CLINICAL IMMUNOLOGY/ALLERGY SPECIALIST**

[ ]  The information provided complies with ASCIA Guidelines - Adrenaline Injector Prescription

[ ]  Assessment by clinical immunology/allergy specialist recommended

Name:

Date: Signed:

Comments: