

Please complete and fax back to Compass Immunology Clinic **FAX 07 38473257** or email reception@immunologyclinic.com.au

Request for adrenaline autoinjector to be provided on PBS Authority prescription by Clinical Immunologist / Allergist

Please refer to the ASCIA adrenaline autoinjector prescription guidelines on the ASCIA website:

<http://www.allergy.org.au/health-professionals/hp-information/asthma-and-allergy/anaphylaxis/11-ascia-guidelines-for-adrenaline-autoinjector-prescription>

Prescribing doctor details

Doctor's name	
Email address	
Provider number	
Phone	
Address	
Fax	
Date	
Signature	

Patient Details

Patient name	
Date of Birth	
Date of last reaction	
Suspected allergen	
Confirmed by skin testing?	Yes / No
Confirmed by sIgE/RAST?	Yes / No
Did the patient have an anaphylactic reaction?	Yes / No
Or a severe generalised allergic reaction?	Yes / No
Modifying factors	
Asthma	Yes / No
Adolescent or young adult	Yes / No
Nut allergy (peanut or tree nut)	Yes / No
Sting insect allergy (bee, wasp, ant)	Yes / No
Co-morbid disease (e.g. IHD, COPD)	Yes / No
Limited access to emergency care	Yes / No

Has the patient been given an Action Plan for Anaphylaxis? (This is a PBS requirement.)	Yes / No
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Would you like this patient to be seen by the clinical immunologist / allergist?	Yes / No
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(If so, please provide a referral letter and contact details for the patient so an appointment may be arranged)

For completion by the clinical immunologist / allergist

The information provided complies with adrenaline autoinjector prescription guidelines.	Yes / No
Assessment by immunologist / allergist recommended.	Yes / No
Dr. David Heyworth-Smith signature:	Date:

NB. Decisions about patient advice on adrenaline autoinjectors and instructions for use remain the responsibility of the prescribing doctor.