ENT & Allergy Specialists

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Patrick J. Haas, M.D.
Manuel S. Villareal, M.D.
Perry S. Poteet, M.D.
Nathan D. Wiebracht, M.D.
Amber L. Boots, APRN

REQUEST FOR ADMINISTRATION OF IMMUNOTHERAPY (SCIT) AT AN OUTSIDE MEDICAL FACILITY

Please complete this form if the allergy injections will be administered at a facility other than the office of ENT & Allergy Specialists.

I have read and signed the "Consent for Administration of Immunotherapy (SCIT / Allergy Injections)." However, I wish to have my injections administered at another medical facility (designated below), and I request that ENT & Allergy Specialists transfer my vaccine vial(s), along with instructions for administration of the injections, to the designated physician / facility. I understand that ENT & Allergy Specialists has no legal or financial arrangement with the designated facility. I understand that it is my responsibility to make certain that the facility and its staff are willing and able to provide allergen immunotherapy. I agree that I will not attempt to administer my allergy injections to myself nor will I permit anyone who is not a licensed physician or under the direct supervision of a licensed physician, to administer the injections. I further agree to notify ENT & Allergy Specialists if I transfer my vaccine vial(s) to any physician / facility other than the one designated below. I understand that I may call ENT & Allergy Specialists office at any time if questions or problems develop and that I may also return at any time to ENT & Allergy Specialists office for continued administration of my injections.

Financial arrangements for purchase of the vaccine vial(s) as well as transportation charges e.g. Fed Ex, will be made through ENT & Allergy Specialists office. Financial arrangements for the administration of the allergy injections, as well as for the treatment of adverse reactions to the injections, will be made with the facility where the injections are administered.

_____ _____

Printed name of Immunotherapy Patient **Date of Birth**

_____ _____

Patient Signature (or Legal Guardian's Signature) **Date Signed**

_____ _____

Witness **Date Signed**

TRANSFER VACCINE TO:

Physician Name: _____

Address: _____

City/State/Zip: _____

Telephone: _____

Fax: _____

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Date: _____

To: _____

Fax: _____

PATIENT: _____

DOB: _____

Dear Doctor:
Guidelines for the administration of subcutaneous immunotherapy (SCIT / allergy injections) now recommend that the prescribing allergist, when asked to forward a patient's extract vial(s) to another physician's office for administration, confirms that the designated physician is able and willing to administer the allergy injections. The above referenced patient has been evaluated in my clinic and has been prescribed allergen immunotherapy as a part of the treatment plan for an allergic respirator disorder. The patient (or parent/legal guardian) has requested that I forward the allergen extract (along with detailed treatment instructions) to you for administration in your office.

This letter is to confirm your participation in the administration of immunotherapy to this patient. Upon return receipt, my office will keep this letter on file in the patient's chart for all future requests concerning extract sent to your office. After reviewing the acknowledgement written below, please sign (X) and return this page via fax to my office. Also, please provide your street address for delivery of the extract vials via courier. Thank you for your help in this matter.

Sincerely,
ENT & Allergy Specialists
Phone: (859) 781-4900
Fax: (859) 572-3036

ACKNOWLEDGEMENT

My signature below acknowledges that my staff and I will administer allergen subcutaneous immunotherapy (SCIT) injections for this patient in a supervised medical setting (immediate physician availability). Furthermore, I acknowledge the following facts: (1) that my staff and I are trained in the recognition and management of both local and systemic reactions to allergen immunotherapy; (2) that my staff and I understand that ENT & Allergy Specialists and their staff will be available for phone consultations as needed, but cannot be responsible for the training or supervision of my office personnel, for procedures performed within my office, or for any quality control measures within my office; and (3) that I understand that the patient may return to ENT & Allergy Specialists at any time for continuation of immunotherapy, if so requested by me or the patient.

Acknowledged and agreed to by: X _____ _____
Physician Signature Date

Send extract vial(s) and instructions to the address below:

_____

_____

_____