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Immunotherapy Treatment Acknowledgement Letter For Allergy Shots Administered At an Outside Medical Facility

Patient Name: _____ DOB: _____

Guidelines for immunotherapy administration (allergy injections) recommend that the prescribing allergist (when asked to forward a patient's extract vial(s) to another physician office for administration) confirms that the designated physician is able and willing to administer the allergy injections. Our office has compiled a summary of important points to comply with allergy shots in the document titled: **IMMUNOTHERAPY POLICIES & PROCEDURES**. If any questions should arise which are not answered or explained fully in this document, please contact our office as we are here to help in any and every way possible. For full detailed information, please refer to the Immunotherapy: Practice Parameters published by the Joint Council of Allergy, Asthma, and Immunology (JCAAI).

The above referenced patient has been evaluated in our clinic and has been prescribed immunotherapy as a part of the treatment plan for allergic respiratory disorder and/or stinging insect hypersensitivity. The patient (or parent/legal guardian) has requested that I forward the allergy extract (along with detailed treatment instructions) to you for administration in your office.

The 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 below and return this page to our office. Also, please provide your street address for the delivery of the extract vials, or the patient may bring you the vials.

My signature below acknowledges that (1) my staff and/or I will administer allergen immunotherapy in the medical office; (2) I will manage both local and systemic reactions to immunotherapy; (3) that my staff and I understand that the prescribing allergist and his/her staff will be available for phone consultation 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 (4) that I understand that the patient may return to our office at any time for continuation, if so requested by me or the patient.

Physician Signature: _____ Date: _____

Physician Name: (print) _____

Extracts will be administered at (address & contact information):

I have read (new patient) or re-read (established patient) all the information about allergy injections, and I agree that I will receive my injections in a medically supervised setting.

Patient Signature: _____ Date: _____

If Minor: Name of Legal Guardian: _____

Legal Guardian Signature: _____ Date: _____

**Please fax and mail this page back at the address provided above.
Please complete this form *BEFORE* administration in your office. Thank You.**