Request for Administration of Immunotherapy at an Outside Medical Facility

I have read and signed the "Consent for Administration of Immunotherapy." However, I wish to have my injections administered at another medical facility (designated below), and I request that Allergy Partners transfer my vaccine vial(s), along with instructions for administration of the injections, to the designated physician / facility.

I understand that Allergy Partners:

- Has no legal or financial arrangement with the designated facility.
- Cannot assume responsibility for my medical treatment within 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
- Manage any immediate or delayed adverse reactions that may result from the immunotherapy.

I agree that I will not:

- Attempt to administer my allergy injections to myself
- 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 this office if I transfer my vaccine vial(s) to any physician / facility other than the one designated below.

I understand that Allergy Partners will not be able to refill my allergen immunotherapy unless the designated physician/facility has returned a signed copy of the "Immunotherapy Administration Acknowledgement Letter."

If I have not yet identified a physician/facility to administer my Immunotherapy and Allergy Partners has elected to provide me my vaccine vial(s) pending that, I will:

- Identify a physician/clinic as soon as practical
- Not administer my immunotherapy myself or at any location not able to safely administer my immunotherapy
- Have the physician/facility return the "Immunotherapy Administration Acknowledgement Letter" to Allergy Partners

Again, I understand that Allergy Partners will not be able to refill my allergen immunotherapy unless the designated physician/facility has returned a signed copy of the "Immunotherapy Administration Acknowledgement Letter."

I understand that I may call this office at any time if questions or problems develop and that I may also return at any time to this office for continued administration of my injections.

Financial arrangements for purchase of the vaccine vials will be made through our 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

OUTSIDE MEDICAL FACILITY:

Facility/Physician____

Address: ____

____

City/State/Zip: ____

Telephone: ____

Fax: ____