Allergy, Asthma & Immunology of the Rockies, P.C.

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Request for Administration of Allergen Immunotherapy in Your Office

To: Date:

Phone #: Fax #:

Patient: D.O.B:

Dear Doctor:

Guidelines for the administration of subcutaneous immunotherapy (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, confirm 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 respiratory 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 or mail to my office. Also, please provide your street address for delivery of the extract vials via mail. Thank you for your help in the matter.

Sincerely,

Robert McDermott, MD | Regan Pyle, DO

ACKNOWLEDGMENT

My signature below acknowledges that my staff and I will administer allergen subcutaneous immunotherapy 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 Dr. McDermott and his staff will be available for phone consultation as needed, but cannot be responsible for the training and supervision of my office personnel, for procedures performed within my office, or for any quality control measured within my office: (3) that I understand that the patient may return to Dr. McDermott's office at any time for continuation of immunotherapy, if so requested be me or by the patient.

Acknowledged and agreed to by:	Send extract vial(s) and instructions to (street address):
X _____ _____ Physician's signature Date	_____ _____ _____

Please fax completed form to AAIR at 970-947-0601. Thank you.