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

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Immunotherapy

Request for Administration of Allergy Injections at an Outside Medical Facility

Please complete this form if the allergy extract will be administered at a medical facility other than the office of the allergist-immunologist.

I have read and signed the *Consent for Administration of Allergy Injections*. However, I wish to have my injections administered at the medical facility designated below, and I request that my extract vial(s), along with instructions for administration of the injections, be forwarded to the medical facility designated below. It is my responsibility to make certain that the facility and its staff are willing and able to provide allergy immunotherapy, and able to recognize and treat immediate or delayed adverse reactions that may result from the immunotherapy. I agree that I will not attempt to administer my extract injections to myself nor will I permit anyone who is not a licensed physician, or under the supervision of a licensed physician, to administer the extract injections. I further agree to notify this office if I transfer my immunotherapy extract vial(s) to any medical facility other than the one designated below. I understand that I may call this office at any time if questions or problems develop, and that I also may return at any time to this office for continued administration of my injections.

_____
Printed Name of Immunotherapy Patient

_____ _____
Patient Signature (or Legal Guardian) Date Signed

_____ _____
Witness Date Signed

NAME, ADDRESS, AND PHONE NUMBER OF THE PHYSICIAN WHO WILL SUPERVISE THE ADMINISTRATION OF THE ALLERGY INJECTIONS:

Physician Name:_____

Street Address: _____

City/State/Zip:_____Phone: _____

Approved:

_____, M.D. _____

Date Signed