REGIONAL
ALLERGY ASTHMA & IMMUNOLOGY CENTER

W. JAN KAZMIER, M.D., Ph.D., FAAAAI • SHAILEE MADHOK, M.D., FACAAI

Phone 423-246-6445 Fax 423-246-8240

2312 KNOB CREEK ROAD, SUITE 206
JOHNSON CITY, TN 37604

2995 FT. HENRY DRIVE, SUITE 100
KINGSPORT, TN 37664

REQUEST FOR ADMINISTRATION OF IMMUNOTHERAPY AT A REMOTE MEDICAL FACILITY

(Please complete this form if the allergy injections will be administered at a facility other than The Regional Allergy, Asthma & Immunology Center, PC)

I have read and signed the **"Consent for Administration of Immunotherapy (Allergy Injections)".** However, I wish to have my injections administered at another medical facility (designated below), and I request that Dr. Shailee Madhok or Dr. W. Jan Kazmier transfer my vaccine vial(s), along with instructions for administration of the injections, to the designated physician/facility. I understand that Dr. Madhok/Dr. Kazmier has no legal or financial agreement with the designated facility. I further understand that Dr. Madhok/Dr. Kazmier 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, as well as the management of 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 nor will I permit anyone who is not a licensed physician/provider, or under the direct supervision of a licensed physician/provider, to administer the injections. I further agree to notify Dr. Madhok/Dr. Kazmier if I transfer my vaccine vial(s) to any physician/facility other than the one designated below. I understand that I may call RAAI Center at any time if questions or problems develop and that I may also return at any time to RAAI Center for continued administration of my injections.

*Financial arrangements for purchase of the vaccine vials will be made through RAAI Center. 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.

A $10 fee will be charged for mailing vials. This will have to be paid before vials can be mailed.

Printed Name of Immunotherapy Patient	Date of Birth
Patient Signature (or Legal Guardian)	Date Signed
Witness	Date Signed

TRANSFER VACCINE TO:

Physician Name: _____
Address: _____
_____
City/State/Zip: _____
Telephone: _____
Fax: _____
_____
_____

FOR OFFICE USE ONLY:

Confirmation
Transfer Agreement Rec'd From:
_____
Date: _____
Approved by: _____
Date: _____
Date Extract Transferred: _____
_____

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URGENT FAX – PLEASE RESPOND IMMEDIATELY

Date:

To:

Fax:

Patient: _____ **DOB:** _____

Dear Doctor/Provider:

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, confirms that the designated physician/provider is able and willing to administer the allergy injections. The above referenced patient has been evaluated in our clinic and has been prescribed allergen immunotherapy as 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 our office.* Also, please provide your street address for delivery of the extract vials via courier. Thank you for your help in this matter.

Sincerely,
W. Jan Kazmier, MD, PhD
Shailee Madhok, MD
RAAI Center Staff

ACKNOWLEDGEMENT

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 allergy immunotherapy; 2) that my staff and I understand that Dr. Kazmier/Dr. Madhok and their 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 3) that I understand that the patient may return to RAAI Center at any time for continuation of immunotherapy, if so requested by me or by the patient.

Acknowledged and agreed to by:

*X*_____

Physician/Provider Signature

Date: _____

_____

Send extract vial(s) and instructions to:

_____

_____

_____

_____

- Please fax this page back to The Regional Allergy, Asthma & Immunology Center, PC.

Thank you. (Fax: 423- 246-8240)