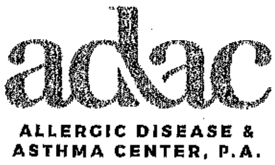

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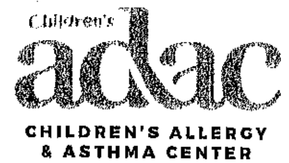

IMMUNOTHERAPY TREATMENT ACKNOWLEDGEMENT FORM

Patient Name: ______________________________ Date of Birth: ________________

Dear Doctor,

Guidelines for the administration of allergen immunotherapy (Allergy Injections) now recommend that the prescribing allergist, when ask to forward a patient's extract vial(s) to another physician's office for administration, confirms that the designated physician is able and willing to administer the allergy injections. The above reference 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 has requested that I forward the allergen extract (along with detailed treatment instructions) to 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 medical record for all future requests concerning extract sent to your office. After reviewing the acknowledgement written below, please sign and return this page via email to extractlab@allergicdisease.com or fax to our office at (864) 672-2654. Once this document is signed and returned, the patient's vial(serum) will be ordered. Thank you for your assistance in the care of this patient. Please do not hesitate to contact our office with any questions or concerns.

Kind regards,

____________________________________ ______________

Prescribing Allergist Signature Date

Acknowledgement

My signature below acknowledges that my staff and I are properly train to administer allergy injections and that we recognize the sign and symptoms of anaphylaxis and we have the training as well as the equipment and medications required to treat such reactions in my office. I understand that the patient is to remain for observation for 30 minutes after every single allergy injection to monitor for symptoms of an adverse reaction. I understand that an appropriately trained provider will need to remain on site during that period to monitor the patient. I agree that I will notify Allergic Disease and Asthma of any systemic reactions by the patient. I agree to review and follow the Allergic Disease and Asthma Immunotherapy Treatment Instructions and contact them with any questions I may have regarding the administration of immunotherapy to this patient. Finally, I understand that the patient may return to the above prescribing allergist's office at any time for continuation of immunotherapy, if requested by me or the patient.

Acknowledged and agreed to by:

____________________________________ ______________

Provider's Signature Date

____

Print Physician's Name and Office Address with Phone Number

MAULDIN OFFICE	GREENVILLE OFFICE	SPARTANBURG OFFICE	EASLEY OFFICE
1202 E. Butler Rd.	2 Butternut Dr.	3020 Reidville Rd.	5155 Calhoun Memorial Hwy, Suite FF
Greenville, SC 29607	Greenville, SC 29605	Spartanburg, SC 29301	Easley, SC 29640
PH: 864-627-3800	PH: 864-295-2492	PH: 864-699-4870	PH: 864-442-5176
Fax: 864-672-2654	Fax: 864-672-2654	Fax: 864-672-2654	Fax: 864-672-2654