Before extract will be made, we must have this form filled out completely, signed and returned to us.

Physician Acknowledgement to Administer Allergy Immunotherapy in their Office

Date: _____

To: _____Allergy Clinic Of Tulsa Attn: Extract Admin_____ Fax: ____918-806-7755_____

Patient Name: _____

DOB: _____

Guidelines for the administration of 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 is able and willing to administer the allergy injections. The above referenced patient has been evaluated at the Allergy Clinic of Tulsa 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 we 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 and return this page via fax or mail to us. Also, please provide your street address for delivery of the extract vials via courier. Thank you for your help in this matter.

ACKNOWLEDGEMENT

My signature below acknowledges that my staff and I will administer allergen immunotherapy injections for this patient in a supervised medical setting (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 that the Allergy Clinic of Tulsa 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 the Allergy Clinic of Tulsa at any time for continuation of immunotherapy, if so requested by me or by the patient.

Acknowledged and agreed to by:

_____ _____

Physician's signature Date

Send extract vial(s) and instructions to: (street address)

_____

_____

_____

Please fax or mail this page back to:

Allergy Clinic of Tulsa, Inc.
ATTN: Extract Administrator
9311 S. Mingo Road
Tulsa, OK 74133-5702
Phone: (918) 307-1613
Fax:(918) 806-7755