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

Patient Requesting Administration of Allergy Immunotherapy in an Outside Medical Facility

Patient Name: _____

Patient Number: _____ DOB: _____

I have read and signed the "Consent for Administration of Immunotherapy (Allergy Injections)" form. However, I wish to have my injections administered at another medical facility (designated below), and I request that the Allergy Clinic of Tulsa transfer my extract vial(s), along with instructions for administration of the injections, to the designated physician/facility. I understand that the Allergy Clinic of Tulsa or its physicians 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, or under the direct supervision of a licensed physician, to administer the injections**. I further agree to notify the Allergy Clinic of Tulsa if I transfer my extract vial(s) to any physician/facility other than the one designated below. I understand that I may call the Allergy Clinic of Tulsa at any time if questions or problems develop and that I may also return at any time to the Allergy Clinic of Tulsa for continued administration of my injections. I understand that the extract can only be stored at the provider's clinic.

Financial arrangements for the purchase of the extract vial(s) will be made through the Allergy Clinic of Tulsa. 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.

_____

Patient or legal guardian's signature Date signed

Please have patient sign

_____

Witness Date signed

Administering Provider

Facility Name: _____

Physician Name: _____

Address: _____

_____

City/State/Zip: _____

Phone Number: _____

Fax Number: _____

Should you desire a change in the way your extract is delivered in the future, please notify our office as soon as possible.

FAX: 918-806-7755

TO AVOID UNNECESSARY DELAYS IN PROCESSING YOUR EXTRACT ORDER- PLEASE MARK BELOW HOW YOU WOULD LIKE TO RECEIVE YOUR EXTRACT FROM OUR OFFICE

Experience with the US Mail has not been uniformly good. It is best to keep extract refrigerated, though being out for short periods of time does no harm – except perhaps with very hot weather and / or with freezing weather which may damage the extract Therefore, we have looked for alternative methods of delivery, which involve additional expense.

- **If lost or damaged there will be a duplicate charge for the replacement which will be the patient's responsibility.**

Your choices for shipping are:

___ FED-EX overnight: prices start @ $45 and go up based on location of delivery.

OR

___ Flat Rate Priority ($7.50) any orders being shipped will require a credit card on file.
Charges will occur at the time of shipping.

OR

___ Patient will pick up–Patient assumes full responsibility. (Please indicate which office you would like to pick your extract up at by writing an **M** Mingo or **U** Utica or **O** Olympia or **N** Owasso or **B** Bartlesville office.