Immunotherapy Treatment Acknowledgement Letter

PATIENT NAME _____

DOB: _____

Dear Doctor:

Guidelines for the administration of allergen 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 in our clinic and has been prescribed allergen immunotherapy as a part of the treatment plan for an allergic respiratory disorder, or stinging insect hypersensitivity. 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 overnight delivery of the extract vials, or the patient may bring you the vials after receiving the first dose in our office. Thank you for your help in this matter.

Sincerely,

_____ _____

Prescribing Allergist's Signature **Date**

ACKNOWLEDGEMENT

My signature below acknowledges that my staff and I will administer allergen immunotherapy and management of both local and systemic reactions to allergen immunotherapy; (2) that my staff and I understand that the prescribing allergist and his/her 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 (3) that I understand that the patient may return to the above prescribing allergist's office at any time for continuation of immunotherapy, if so requested by me or the patient.

Acknowledged and agreed to by:

X _____ _____

Physician Signature **Date**

_____

Print Physician Name

Extracts will be administered at (Street Address):

_____

Phone # **Fax #**

Please fax this page back to the above prescribing allergist at the fax number noted above *BEFORE* administration in your office. Thank you.