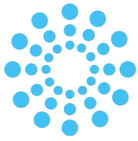

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PATIENT REQUEST FOR ADMINISTRATION OF IMMUNOTHERAPY AT AN OUTSIDE MEDICAL FACILITY

I, ____, request the Indiana Allergy And Asthma LLC to release my allergy extract to me to have it administered at an outside health care facility. I make this request because I wish to go (or my insurance mandates I go) to another health care facility to continue my treatment program.

I understand that I may have a serious adverse reaction to my allergy injections, such as tightness in the chest, wheezing and exacerbation of my asthma, generalized itching, fainting or even a severe allergic reaction (anaphylaxis) causing death. Accordingly, I understand and agree that treatment must be carried out at a health care facility where skilled personnel are able to safely administer my allergy injections, regulate doses in accordance to my response and the dosage schedule and correctly diagnose and treat any adverse reactions I may have following my injection(s). I understand the medical equipment and personnel will be immediately available to treat me for an adverse reaction, if necessary. Furthermore, I will agree to wait a minimum of **30 minutes** following my allergy injection(s).

I recognize and acknowledge that the self-administration of my allergy extract or injections by persons outside of a health care facility is against medical advice and I will **NOT** allow this to occur.

I have had a verbal explanation of the procedure for allergy injections, recommended dosage schedule, signs and symptoms of a potential life threatening adverse reaction and the need to wait a minimum of **30 minutes** after my injection(s).

I agree to have my epinephrine with me in case of a life-threatening reaction. I acknowledge that I have received instructions on its use and administration. I further understand that I must periodically check that my epinephrine is not expired and will call the office for a renewal if needed. I understand that it is my responsibility to maintain follow up appointments with Pooja Oza Patel, MD. Failure to do so may lead in a delay of serum renewal.

I have had an opportunity to ask questions and have received answers to my questions.
I will not hesitate to consult the clinical staff at the Indiana Allergy And Asthma if additional questions or concerns arise. I herby release the Indiana Allergy And Asthma LLC and its staff from any liability should any future injury occur to me from incorrect administration of the extract.

________________________________ ________________________________
Patient's Name (Print) Witness

________________________________ ________________________________
Patient's Signature Date