



**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/legal guardian sign**

### **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: \$7.50 ACT Handling Fee Plus FED-EX Prices start @ \$45 and up based on location of delivery.

**OR**

\_\_\_\_ Priority (\$7.50 ACT Handling Fee Plus, \$10.00 and up, based on location of delivery) 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.