

**ALLERGY AND ASTHMA ASSOCIATES, PC**

Richard C. Loria, MD

Courtney J. Blair, MD

Penny Flores, FNP

Board Certified Physicians in Allergy and Immunology

**REQUEST FOR ADMINISTRATION OF IMMUNOTHERAPY  
AT AN OUTSIDE MEDICAL FACILITY**

**(Please complete this form if your allergy injections will be administered  
at a facility other than the offices of Dr. Loria, Dr. Blair or Penny Flores, FNP**

I have read and signed the "Consent for Administration of Immunotherapy (Allergy Injections)."

I wish to have my injections administered at the medical facility designated below.

I request to: **(please check one)**

**pick up my vials** at the     Sterling office         Mclean office    . **There is a \$10 charge for packing the serum to take out.** This cannot be charged to insurance and will be payable at the time of pick-up. Serum must be delivered within three hours of pick-up to the administering facility

**have my serum mailed.** **The cost is \$20 PLUS the Fed EX Standard Overnight charges.** This cannot be charged to insurance and will be payable when the serum is shipped. Serum is shipped on Monday, Tuesday or Wednesday for 24 hour delivery. If the destination office is closed during the week and cannot accept delivery, please inform the lab. If no one is available to sign for the delivery and the serum is delayed over 24 hours, the serum will not be safe to use. The patient will be responsible for any serum replacement costs and additional shipping charges.

**I understand that I must schedule a nurse visit in order to pick up my vials or have my vials mailed.** I will receive written instructions for administration of the injections. I understand that Dr. Loria, Dr. Blair and Ms. Flores have no legal or financial arrangement with the designated facility. I further understand that Dr. Loria, Dr. Blair and Ms. Flores 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. **The receiving facility must have a physician supervising the shots and have oxygen and adrenalin available.** I understand that I may not keep my extracts at home. 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 that I will not transfer my vaccine vial(s) to any facility other than the one designated below.** I understand that I may call Allergy and Asthma Assoc. at any time if questions or problems develop and that I may also return at any time to Allergy and Asthma Assoc. for continued administration of my injections.

I understand that I will be responsible for the cost of the transfer of the vaccine vials to the designated facility as outlined above. 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.

\_\_\_\_\_  
**Printed Name of the Immunotherapy Patient**

\_\_\_\_\_  
**Date of Birth**

\_\_\_\_\_  
**Patient (or Legal Guardian's) Signature**

\_\_\_\_\_  
**Date Signed**

**Transfer Extract To:(to be completed by the patient)**

**Physician's Name:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Fax Number:** \_\_\_\_\_

**City/State/Zip:** \_\_\_\_\_