



SHAILEE MADHOK, M.D., FACAAI

Phone 423-246-6445 Fax 423-246-8240

2312 KNOB CREEK ROAD,
SUITE 206
JOHNSON CITY, TN 37604

8 SHERIDAN SQUARE,
SUITE 201
KINGSPORT, TN 37660

16000 JOHNSTON MEMORIAL DRIVE,
SUITE 212
ABINGDON, VA 24211

URGENT FAX – PLEASE RESPOND IMMEDIATELY

Date:

To:

Fax:

Patient: _____ **DOB:** _____

Dear Doctor/Provider:

Guidelines for the administration of subcutaneous 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/provider 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 part of the treatment plan for an allergic respiratory disorder. 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 delivery of the extract vials via courier. Thank you for your help in this matter.

Sincerely,
Shailee Madhok, MD
RAAI Center Staff

ACKNOWLEDGEMENT

My signature below acknowledges that my staff and I will administer allergen subcutaneous immunotherapy injections for this patient in a supervised medical setting (immediate physician availability). Furthermore, I acknowledge the following facts: 1) that my staff and I are trained in the recognition and management of both local and systemic reactions to allergy immunotherapy; 2) that my staff and I understand that Dr. Madhok and their 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; and 3) that I understand that the patient may return to RAAI Center at any time for continuation of immunotherapy, if so requested by me or by the patient.

Acknowledged and agreed to by:

Send extract vial(s) and instructions to:

X _____
Physician/Provider Signature
Date: _____

- Please fax this page back to The Regional Allergy, Asthma & Immunology Center, PC.
Thank you. (Fax: 423- 246-8240)



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REQUEST FOR ADMINISTRATION OF IMMUNOTHERAPY AT A REMOTE MEDICAL FACILITY

(Please complete this form if the allergy injections will be administered at a facility other than
The Regional Allergy, Asthma & Immunology Center, PC)

I have read and signed the **“Consent for Administration of Immunotherapy (Allergy Injections)”**. However, I wish to have my injections administered at another medical facility (designated below), and I request that Dr. Shailee Madhok transfer my vaccine vial(s), along with instructions for administration of the injections, to the designated physician/facility. I understand that Dr. Madhok has no legal or financial agreement with the designated facility. I further understand that Dr. Madhok 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/provider, or under the direct supervision of a licensed physician/provider, to administer the injections. I further agree to notify Dr. Madhok if I transfer my vaccine vial(s) to any physician/facility other than the one designated below. I understand that I may call RAAI Center at any time if questions or problems develop and that I may also return at any time to RAAI Center for continued administration of my injections.

*Financial arrangements for purchase of the vaccine vials will be made through RAAI Center. 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.

A \$10 fee will be charged for mailing vials. This will have to be paid before vials can be mailed.

ALLERGY & ASTHMA

1100 JOHNSON MEMORIAL DRIVE
ABINGDON, VA 22003
Phone 434-246-4444 Fax 434-246-4440

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Phone 434-246-4444 Fax 434-246-4440

REQUEST FOR ADMINISTRATION OF IMMUNOTHERAPY AT A REMOTE MEDICAL FACILITY

Please complete this form if the physician will be administering immunotherapy at a remote medical facility. The National Allergy & Asthma Society (NAAS) is the sponsor of this program.

I have read and agree to the Request for Administration of Immunotherapy (NAAS Form 100-1) and to have my practice administered at a remote medical facility (this is not a new facility, but a facility that has been previously approved by NAAS). I understand that the NAAS will not be responsible for the administration of the immunotherapy at the designated facility. I understand that Dr. Mascher has no responsibility for the administration of the immunotherapy at the designated facility. I understand that Dr. Mascher cannot assume responsibility for a medical procedure at the designated facility. I understand that it is the responsibility of the designated facility to ensure that the facility and its staff are properly trained and able to provide all the immunotherapy services as well as the management of any medical emergencies that may arise and that may result from the immunotherapy. I agree that I will not attempt to administer my allergy injections at my office or at any other location which is not a designated facility or under the direct supervision of a licensed physician. I agree to administer the injections at the designated facility only. I agree to transfer my vaccine vials to the designated facility after the one designated below. I understand that my vials will be stored at the designated facility and I will be responsible for the continued administration of my injections. I also understand that my vials will be stored at the designated facility.

I understand that the designated facility will be responsible for the purchase of the vaccine vials and will be responsible for the storage of the vaccine vials. I understand that the designated facility will be responsible for the administration of the immunotherapy. I understand that the designated facility will be responsible for the management of any medical emergencies that may arise and that may result from the immunotherapy.

I understand that the designated facility will be responsible for the purchase of the vaccine vials and will be responsible for the storage of the vaccine vials. I understand that the designated facility will be responsible for the administration of the immunotherapy. I understand that the designated facility will be responsible for the management of any medical emergencies that may arise and that may result from the immunotherapy.

Printed Name of Immunotherapy Patient

Date of Birth

Patient Signature (or Legal Guardian)

Date Signed

Witness

Date Signed

TRANSFER VACCINE TO:

Physician Name: _____

Address: _____

City/State/Zip: _____

Telephone: _____

Fax: _____

FOR OFFICE USE ONLY:

Confirmation

Transfer Agreement Rec'd From:

Date: _____

Approved by: _____

Date: _____

Date Extract Transferred: _____

Date of Birth Date of Issue Date of Expiry FOR OFFICIAL USE ONLY Confirmed by Date of Issuance Date Approved by Date Date of Review 	Patient Name Patient Address Patient Phone Patient Email Patient Signature Patient Date Patient ID
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