



## IMMUNOTHERAPY (ALLERGY SHOTS) TRANSFER FORM *Outside of AllerVie Health*

AllerVie Health allows your allergy shot vials to be transferred to another office or practice under the agreed to supervision of a licensed physician. Please sign and fully complete the form below to transfer your injections to another facility.

- I have read and signed the consent and instruction form for the Administration of Allergy Injections.
- I wish to have my injections administered at the medical facility below. I have confirmed that the staff is willing and able to provide allergy immunotherapy and able to recognize and treat immediate or delayed adverse reactions that may result from the immunotherapy. I agree that I will not attempt to administer allergy shots to myself, nor will I permit anyone who is not a licensed physician or under the supervision of a licensed physician, to administer my allergy immunotherapy. I further agree to notify this office if I transfer my care and or vials to any medical facility other than the one I designate below.
- I understand and agree to pay a shipping and handling fee **up to \$15.00** that is not covered by insurance and will be applied to my account each time my vials are mailed to an outside facility.
- I understand that my vials will not be transferred to another facility until this form is received and signed by the supervising physician designated below.

Patient Name: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

Parent/ Guardian Name (If Applicable): \_\_\_\_\_

Patient or Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I agree to administer immunotherapy for this patient in my office. I am aware of the storage requirements for the shot vials and agree to receive and appropriately store the vials. I also agree to monitor the patient for the appropriate wait time after each shot.

Supervising Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Supervising Physician Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

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

Phone: \_\_\_\_\_

**THIS FORM SHOULD BE COMPLETED AND FAXED TO YOUR LOCAL ALLERVIE HEALTH OFFICE.  
IF YOU HAVE ANY QUESTIONS, PLEASE CALL YOUR LOCAL ALLERVIE HEALTH OFFICE.**