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 **$5.00** shipping and handling fee 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.