Revere Health Allergy & Immunology

Henry Yeates, MD • Tammy Jacobs, MD

(Office Only) MRN: _____

PATIENT NAME: _____

DOB: ____/____/_____ **AGE:** _____ **SEX: M / F**

DATE: ____/____/_____

SUBCUTANEOUS IMMUNOTHERAPY (ALLERGY SHOT) RELEASE FORM

Dear Doctor:

_____ has requested that you accept his/her allergy extracts for supervision and administration of allergy injections. Since this procedure involves the injection of materials to which the patient is allergic, there is a potential risk involved. The American Academy of Allergy and Immunology has advised that all allergy injections be administered in a medical facility equipped to promptly deal with any severe reactions, such as: anaphylaxis, hives, rhino-conjunctivitis, angioedema, asthma, laryngeal edema, hypotension and shock. Therefore, extracts are not to be released to patients for home use.

Historically, a small percentage of patients receiving allergy injections experience reactions, the vast majority of which are large local swelling, hives, rhinitis and conjunctivitis. Asthma and shock are unusual, and death is exceedingly rare. (Millions of people are on immunotherapy in the U.S. with about 2 reported deaths per year.)

You do not have to personally administer the injections, although you may, but your presence will be required for at least 30 minutes after the injection, should there be a need to treat any anaphylactic reactions.

We will provide you with the extracts for injections, advancement schedules, guidelines for "missed injections", guidelines for treatment of anaphylaxis and any further instructions that you may require. Thank you for your assistance. If you have any questions, please do not hesitate to call our office.

Sincerely,

Henry Yeates, M.D.
Tammy Jacobs, M.D.

Please sign and fill out this entire form and return it to our office if you are willing to supervise the administration of

_____'s allergy injections.

Physician's Name: _____ Phone: _____

Address: _____ Fax: _____

_____

Physician's Signature: _____ Date: _____