LAFAYETTE

BAILEY HEALTH CENTER

Referring Allergist Agreement

Your patient _________________________. DOB _______________ is requesting to receive injections of allergy extracts provided by your office, at Lafayette College. Consistent with our policies we ask that you, as the prescribing and referring Allergy/Immunology licensed independent provider, complete and return the Allergy Immunotherapy Order Form with a signed copy of this referral agreement.

I agree that:

- I will provide allergen immunotherapy extracts in adequately labeled vials with patients first and last name, date of birth, contents and expiration date.
- The allergen immunotherapy extracts will be prepared by individuals experienced and trained in handling allergenic products and contain therapeutically effective dosing individually formulated and consistent with current guidelines as outlined within the American Academy of Allergy, Asthma, and Immunology Practice Parameters and guidelines.
- I will complete the Allergy Immunotherapy Order form to provide detailed directions regarding dosage schedule for build-up phase and/or maintenance, and instructions on adjustments that might be necessary under the following circumstances:
    - ~ The use of new vials.
    - ~ If the components of the allergen immunotherapy extract have changed; these include changes in the lot, manufacturer, component allergens and their respective concentrations in the extract.
    - ~ During seasonal exposure to allergens that are in the patient's allergen vial to which the patient is very sensitive.
    - ~ If the patient has missed injections.
    - ~ When reactions occur to the allergen immunotherapy extract.
- I will continue to be responsible for the management of this patient's immunotherapy and the modification of doses during therapy.
- I will reevaluate this patient at least every 6-12 months.
- I will be available by phone to the medical assistants, nurses, and providers at Bailey Health Center should questions or problems arise with this patient's immunotherapy.
- I understand that Bailey Health Center does not ship vials. **Vials are to be delivered by the patient or shipped to Bailey Health Center 607 High Street Easton, PA 18042.**

Printed name ___________________ Signature ___________________ Date _________