

S. Reed Shimamoto, MD

Allergy Extract Release

Date: _____

Patient Name: _____ Date of Birth: _____

I am requesting the release of my serum to:

1. Name of designated practice where shots will be transferred to as they have agreed to house my serum and administer my serum via injection. _____
2. Name of provider who agrees to oversee immunotherapy _____
3. Phone number of above named practice _____
4. Date you are anticipating to pick up/send your serum _____ Will you be receiving a shot that day? Yes/No

Please initial the following:

- * ___ I understand that my serum is ONLY to be administered by qualified personnel in the designated office above under direct supervision. I understand that the position statement of the AAAAI strongly recommends against home administration of allergen immunotherapy and I understand there have been deaths reported in association with allergen immunotherapy
- * ___ I understand that the serum must be kept at room temperature or cooler until it reaches the office designated below and then be refrigerated upon arrival
- * ___ I understand that I will need to wait 30 minutes in the office after each administered allergy injection.
- * ___ I understand that I will have a yearly serum review at San Tan Allergy & Asthma as the extract will expire 12 months from the date it was made.
- * ___ I understand that I will need to have an epinephrine auto injector (a set of 2) on my person at the time of injections and after. I understand that this will expire yearly and I will need to acquire a new device with each serum review.
- * ___ I will notify San Tan Allergy & Asthma of any major reactions or changes to my serum.
- * ___ I understand that per San Tan Allergy & Asthma practice protocols, I will need to obtain certain shots at San Tan Allergy & Asthma after transferring my serum (such as the first injection after a new serum is made and for certain concentrations).
- * ___ I hereby release San Tan Allergy & Asthma and its agents, successors and assigns of whatsoever kind of nature, arising from and by reason of any and all known and unknown, foreseen and unforeseen bodily and personal injuries, and the consequences thereof, resulting and to result from the administration of said allergy extracts.

Patient/Guardian signature: _____ Date: _____

Witness: _____ Date: _____

To be completed and initialed by San Tan Allergy & Asthma: (Must have everything signed and completed before releasing serum)

- ___ Consent to Administer Form signed by the above named provider's office and scanned into chart.
- ___ Called and spoke with staff member named _____ at the above named providers office on (date) _____ to discuss plan for patient's allergy injections to be transferred to and administered at said office. Conversation documented in patient notes.
- ___ Balance on account paid in full.
- ___ Injection record history prepared, scanned and sent with patient.
- ___ Injection schedule prepared, scanned and sent with patient.
- ___ Blank copy of injection record prepared, scanned and sent with patient.
- ___ Patient to carry out serums. If so, give only the dilutions that will be used until they will return to start their next dilution (stronger dilutions are to be kept in the "patient takes serum out" box). Documented which vials were given to the patient in the patient's notes.
- ___ Serums are to be mailed to receiving provider's office. Documented which vials were mailed and when they were shipped in the patient's notes.

Signature of approving provider here in office: _____