Northwest Asthma & Allergy Center, P.S.

ANTIGEN TRANSFER TO OUTSIDE MEDICAL FACILITY

Clinic where you will be receiving your allergy injections:

Physician/Clinic Name ____

Address ____

____

Phone Number ____

- I agree that I **will not** administer allergy injections to myself/my child. I understand that allergy injections must be given in a medical facility under the supervision of a licensed healthcare provider (physician, nurse practitioner or physician assistant.)
- ***Absolutely NO home injections!***
- I understand that Northwest Asthma & Allergy Center (NAAC) cannot assume responsibility for my medical treatment within the above designated facility
- I further agree to notify NAAC if I transfer my allergen vials to any physician/medical facility other than the one designated above.
- I understand that I may call NAAC at any time if questions arise and that I may return at any time to NAAC for continued administration of my allergy injections.

☐ I agree to transfer my/my child's antigen from NAAC to the above location and for my/my child's injections to be administered there under appropriate medical supervision. I understand that the antigen must be kept refrigerated and protected from freezing and high temperatures. I understand that I am responsible for delivering the antigen to the above location in good condition and will be responsible for any replacement costs if it is lost or damaged while in my possession.

OR

☐ I would like my/my child's antigen mailed to the above address and agree to pay **$20.00** shipping and handling fee not covered by insurance which will be applied to my account.

____ ______________________
Printed Name of Patient | Date of Birth

____ ______________________
Responsible Party/Guarantor Printed Name | Relationship to Patient

____ ______________________
Patient/Responsible Party/Guarantor Signature | Date

FOR CLINIC PURPOSES ONLY

	Staff Signature	Date
Antigen released to patient		
Antigen mailed to above clinic		

FAX COMPLETED FORM TO SEATTLE LAB

206-523-0724

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