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 shipping and handling fees not covered by insurance which will be applied to my account. The fees are **$30.00** to ship within WA state or **$60.00** outside WA state and within USA.

_____   _____
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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