Northwest Asthma & Allergy Center, P.S.

TRANSFER OF CARE/IMMUNOTHERAPY TO NORTHWEST ASTHMA & ALLERGY CENTER

Patient Name	**DOB**
ALLERGIST INFORMATION: **Name:**	
Office #	**Fax #**

☐ **I would like my patient to continue allergy injections at Northwest Asthma & Allergy Center with my continued role as primary allergist.**

☐ **I would like to transfer care of my patient including oversight of allergy care and allergy Injections to Northwest Asthma & Allergy Center.**

Patient has been receiving immunotherapy in my office since:	Date _____
Patient has had a systemic reaction in the past. If yes, please provide date(s) and descriptions: _____ _____	YES NO
Do you require patient to pre-medicate before each shot? If yes, please list medication(s) and minimum hours/minutes before shot(s): _____ _____	YES NO
Do you require patient to carry epinephrine autoinjector on shot days?	YES NO
Does the patient have asthma? Do you require a Peak Flow to be measured before shot(s)? • Minimum Peak Flow to receive injections: _____	YES NO YES NO
Does the patient have a cardiac condition? Is the patient on a beta blocker? Is the patient on an ACE-inhibitor?	YES NO YES NO YES NO

- ☐ Vials must be clearly labeled and correspond with the written instructions & dosage sheets.
- ☐ Please attach the following:
  - ✓ office visit progress notes – at least initial and last visit, list of medications and drug allergies, skin and/or lab test results, and spirometry results (if available)
  - ✓ recipe of antigen mix(es) including expiration date
  - ✓ allergy injection record(s)

FAX TO: Northwest Asthma & Allergy Center
206-523-0724