



**TRANSFER OF CARE/IMMUNOTHERAPY TO  
NORTHWEST ASTHMA & ALLERGY CENTER**

Patient Name		DOB
ALLERGIST INFORMATION: Name:		
Office #	Fax #	
<input type="checkbox"/> I would like my patient to continue allergy injections at Northwest Asthma & Allergy Center with my continued role as the primary allergist.  <input type="checkbox"/> I would like to transfer care of my patient, including oversight of allergy care and allergy injections to Northwest Asthma & Allergy Center.		
The patient has been receiving immunotherapy in my office since:		Date _____
The patient has had a systemic reaction in the past. If yes, please provide the date(s) and descriptions: _____ _____		YES    NO
Do you require the 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 the patient to carry an 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)

<b>FAX TO: Northwest Asthma &amp; Allergy Center (206) 523-0724</b>
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