NORTHWEST ASTHMA & ALLERGY CENTER

ANTIGEN TRANSFER TO OUTSIDE MEDICAL FACILITY

The medical facility that will be accepting your antigen and administering your allergy injections:

Physician/Clinic Name _____

Address _____

Phone Number _____

Days & Hours of Operation _____

- 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.)
- ***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. The transfer will occur:

- ☐ Within 48hrs (if location is Washington State) _____ (initial)
- ☐ Within 72hrs (if location is out of Washington State) _____ (initial)

OR

☐ I would like my/my child's antigen mailed to the above address and agree to pay a **$30.00** shipping and handling fee for addresses inside Washington State and **$60.00** for addresses outside of Washington State. The shipping fee is not covered by insurance and 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****

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

FAX COMPLETED FORM TO SEATTLE LAB

(206) 523-0724

Revised 5.21.26