ENT & Allergy ASSOCIATES, S.C.

# REQUEST FOR ADMINISTRATION OF IMMUNOTHERAPY AT AN OUTSIDE MEDICAL FACILITY

EAR, NOSE & THROAT | ALLERGY & ASTHMA | HEARING CENTER
512 S. 28th Ave Wausau, WI, 54401 | 715-847-2021 | entwausau.com

Please complete this form if the allergy injections will be administered at a facility other than the office of David Edmondson, D.O. or Todd Hostetler, M.D.

I wish to have my allergy injections administered at another medical facility (designated below), and I request that Dr. Edmondson or Dr. Hostetler transfer my vial(s), along with instructions for administration of the injections to the designated physician/facility. I understand that Dr. Edmondson or Dr. Hostetler have no legal or financial arrangement with the designated facility. I further understand that Dr. Edmondson or Dr. Hostetler cannot assume responsibility for my medical treatment within the designated facility.

I understand that it is my responsibility to make certain that the facility and its staff are willing and able to provide allergen immunotherapy, as well as the management of any immediate or delayed adverse reactions that may result. I agree that I will not attempt to administer my injections to myself or will I permit anyone who is not a licensed physician, or under the direct supervision of a licensed physician, to administer the injection. **I further agree to notify Dr. Edmondson or Dr. Hostetler if I transfer my allergy injections to any physician/facility other than the one designated below.**

I understand that I may call Dr. Edmondson's or Dr. Hostetler's office at any time if questions or problems develop and that I may also return at any time to Dr. Edmondson's or Dr. Hostetler's office for continued administration of my injections.

Printed Name of Patient _____ Date of Birth _____

Patient / Parent or Guardian Signature _____ Date Signed _____

Witness _____ Date Signed _____

**TRANSFER EXTRACT TO:**

Physician Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____