certified
ALLERGY & ASTHMA
consultants

Thank you for your interest in receiving allergy injections at our office while you are in the local area.

Your ability to receive your injections at our office requires you to obtain information from your prescribing allergist. We will review the information provided and determine whether we can accept you as a patient of our Practice and administer the injections to you. The information we need is included with this letter and is titled, "**Information from the Prescribing Allergist**". We encourage you to contact your allergist as soon as possible to request they provide the necessary information to us. Please note that we do not accept patients whose allergy injections were prescribed by an Otolaryngologist (ENT physician).

If you are accepted as a patient, we will ask you to abide by certain guidelines for receiving allergy injections in our office. These guidelines include the following.

Annual Physician visits. Prior to receiving your first injection at our office, you will need to be seen by one of our physicians to establish yourself as a patient. The physician will obtain your medical history and perform a brief examination. Each year thereafter you will need a physician visit at our office to update your medical history. This is necessary so that we have current medical information in the event we need to treat you for a reaction to your injections or for your allergies while you are in the area.

Injection visits. Injections are administered on a walk-in basis. You may receive your injections during days and times when your prescribing allergist's office is open. This is necessary in the event we need to contact your allergist about your injections or reactions you may have experienced. We will not administer injections to you during days and times when your allergist's office is closed.

Your injection schedule. Your prescribing allergist will determine your treatment schedule and frequency of your allergy injections. It is your responsibility to maintain that schedule, so you don't fall behind in treatment. If you arrive for an injection and have fallen behind in treatment necessitating that we contact your allergist for dosing instructions, you will not receive your injection that day. After we have received instructions from your allergist we will contact you to receive your injection. Due to the importance of receiving injections on a regular basis and the disruption caused when falling behind in treatment, patients who do so more than twice in the year will not be able to receive their injections in our office.

After injection wait time. Following your injection, we require that you wait 30 minutes in our office. This allows us to monitor you for reactions that may occur following the injection. If you fail to wait the required 30 minutes, we will discontinue your treatment.

Practice limited to allergy, asthma and clinical immunology
Scott L. Osur, MD * Janet L. Claassen, MD * Thomas N. Flaim, MD * Michael G. Katlan, MD
Kris K. Saririan, MD * Ari Kounavis, MD * Kemp W. Bundy, MD * Manisha Relan, MD
www.certifiedallergy.com

8 Southwoods Boulevard
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2231 Burdett Avenue
Troy, NY 12180
phone: 518-272-1515
fax: 518-272-0035

92 East Avenue
Saratoga Springs, NY 12866
phone: 518-886-7675
fax: 518-886-7678

Information from your Allergist. You are responsible for assuring that your prescribing allergist provides the information we need in a timely manner. We are available to answer questions they may have in completing the documentation necessary for us to determine if we can accept you as a patient.

Upon receipt and review of information from your prescribing Allergist, we will contact you to inform you of our decision. If you are accepted as a patient, we'll schedule an appointment for a visit with one of our physicians as discussed above. Please note: The appointment will **not** be scheduled until you have been accepted as a patient.

If you have questions, please contact our office at 518-434-1446. We will be pleased to assist you.

Sincerely,

Certified Allergy & Asthma Consultants

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consultants

(Please enter name and address of your allergist below)

_____

_____

_____

Dear Doctor:

Your patient, _____ D/O/B _____, has requested to receive allergy injections in our office using treatment vials provided by your office. To assist us in determining whether we can accommodate this request, we need certain information from you.

Please note there are certain considerations for patients requesting to receive their injections in our office, which we have outlined below.

- Patient vial labels must be typewritten and contain an expiration date. Handwritten labels and "cross outs" are not acceptable.
- Injection records must be legible and contain unequivocal dosing instructions. These instructions must include directions for increasing patients through to their maintenance dose (interval and dose amount) and instructions for dose reductions if the patient is "late" for their injection or provided new vials.
- The patient will be permitted to receive injections only during the operating hours of your office. This permits us to contact you if needed for consultation.
- Receipt of the documentation we are requesting on the accompanying form is not a guarantee we will administer injections to your patient. A determination on acceptance will be made following review of the information provided by your office.

Please complete the enclosed **Information from the Prescribing Allergist** form and return it to us as soon as possible to allow time for review and follow up with your office should we have questions. If you have questions regarding this request, please contact us at 518-434-1446.

Sincerely,

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8 Southwoods Blvd.
Albany, New York 12211
518- 434-1446

Information from the Prescribing Allergist

Patient Name _____ Date of Birth _____

1. Most recent office notes to include: **Clinical Diagnosis, Skin Test Results, Spirometry results (if asthmatic)**
2. A copy of the injection record indicating the patient's most recent injection to include allergens, date and dose of the last injection, and immunotherapy protocol for dosage increases and reductions.
3. Is the patient on build-up or maintenance phase of immunotherapy? _____
4. Has the patient had any systemic reactions after allergy injections? If yes, please provide documentation.
5. What days and hours is your office is open? _____
6. What is your best contact phone number? _____

COMPLETE FOR PATIENT'S IMMUNOTHERAPY
Please submit 1 page for each vial

Extract Vial	Vial Contents	Concentration For each Allergen (per ml) (Au, pnu, Bau, w/v)	Extract Manufacturer	Diluent In ml	Total Volume In Vial	Expiration Date of Vial

Physician's Name (please print) _____ Date: _____

Physician's Signature: _____

Please forward the information requested by fax to: 518-434-0806