certified
ALLERGY & ASTHMA
consultants

Thank you for your interest in receiving allergy injections at our office while in the area for an extended period of time.

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. Theses guidelines include the following.

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.

Approval and first appointment. 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 will 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. Do not mail vials to our office until you are accepted as a patient.

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 do not 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 then 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 reaction that may occur following the injection. If you fail to wait the required 30 minutes, we will discontinue your treatment.

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 allergies while you are in the area.

At the end of your time with us you are responsible for picking up your vials and returning them to your prescribing allergist.

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

Sincerely,

Certified Allergy & Asthma Consultants

8 Southwoods Boulevard
Albany, NY 12211
phone: 518-434-1446
fax: 518-434-0806

7 Emma Lane
Clifton Park, NY 12065
phone: 518-383-0001
fax: 518-383-5035

2125 River Road
Schenectady, NY 12309
phone: 518-374-2266
fax: 518-374-0500

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

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Important information for your Allergist. Please enter your name and birthdate and provide these documents to your allergist.

Dear Doctor:

Your patient _____ DOB _____, has requested to receive allergy
(insert name) (insert)
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 of acceptance will be made following review of the information provided by your office.

Please complete the **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 if necessary. If you have questions regarding this request, please contact us at 518-434-1446.

Sincerely,

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

CERTIFIED ALLERGY & ASTHMA CONSULTANTS
8 Southwoods Blvd
Albany, NY 12211
Phone: 518-434-1446
Fax: 518-434-2360

Information from the Prescribing Allergist

Patient Name_____Date of Birth_____

Physician: _____Office Phone: _____ Fax: _____

Office Address: _____

Days and hours your office is open_____

Contact person/phone # for questions_____

PLEASE FAX THE FOLLOWING RECORDS:

☐ Most recent office visit note (must have occurred in past 12 months)
☐ Most recent Skin Test results
☐ Most recent Spirometry (if patient is asthmatic)
☐ Injection record including most recent injection
☐ Dosing protocol for each vial/injection

VIAL FORMULA

	NAME of extract vial	Vial Contents	Concentration for each Allergen	Extract Manufacturer	Diluent In ml	Total Volume In Vial	Expiration Date of Vial
1)							
2)							
3)							
4)							
5)							
6)							

PLEASE ANSWER THE FOLLOWING QUESTIONS:

☐ Systemic history _____Yes (if yes, please provide documentation) _____NO

☐ Injection Progress _____In Build-up _____At maintenance

☐ Antihistamine required before injection _____YES _____NO

PLEASE COMPLETE TABLE BELOW:

REDUCTION PROTOCOL FOR MISSED INJECTION

During Build-Up Phase	After Reaching Maintenance
_____to_____days-continue as scheduled	_____to_____days-give same maintenance dose
_____to_____days-repeat previous dose	_____to_____weeks-reduce previous dose by_____ml
_____to_____days-reduce previous dose by____ml	_____to_____weeks-reduce previous dose by_____ml
_____to_____days-reduce previous dose by____ml	Over_____weeks-contact office for instructions
Over_____days-contact office for instructions	

REDUCTION PROTOCOL FOR REACTIONS:

At next visit: Repeat dose if swelling is >_____mm and <_____mm.
Reduce by one dose increment if swelling is >_____mm.

Other instructions:

_____

_____

Physician Signature: _____ Date: _____

PLEASE RETURN THIS FORM WITH REQUIRED DOCUMENTS BY FAX 518-434-2360