Revere Health Allergy & Immunology

Tammy Jacobs, MD ● Joshua Burkhardt, DO

(Office Only) MRN: _____

PATIENT NAME: _____

DOB: ____/____/_____ **AGE:** _____ **SEX: M / F**

DATE: ____/____/_____

SUBCUTANEOUS IMMUNOTHERAPY (ALLERGY SHOTS) SERUM REFILL FORM

1) **Please fill out completely and return or fax back for refills.**
2) **Please attach or fax the injection record form(s) with this request.**
   ***Please allow 2 weeks for serum refills and delivery.

□ **Please check if you have a Medicaid plan**. This may be a covered benefit of your plan, but currently coverage is limited a certain allotted number of units per 12 month period. After that, we will no longer bill insurance, and you will be responsible for the full cost of the refill serums up front. ***If you have a Medicaid plan, you are required to sign an Advance Beneficiary Notice of Noncoverage (ABN) form attesting that you understand your financial responsibility. Please initial _____.***

Bottle: _____ Dilution: _____ Dose: _____

Bottle: _____ Dilution: _____ Dose: _____

Bottle: _____ Dilution: _____ Dose: _____

Provider:
□ Tammy Jacobs, MD □ Joshua Burkhardt, DO

Office use only:
□ J30.9 Allergen
□ J30.1 Pollen
□ J30.2 Seasonal
□ J30.81 Animals
□ J30.89 Dust mite
□ Z91.048 Mold

If you obtain your injections at another physician office (otherwise leave blank) – Delivery options:

□ Office Pick-up. *If you select office pick-up, but are unable to do so, and need us to mail it out instead, we will require a written statement mailed or faxed to us, with S&H payment prior to shipment (payment can be made over the phone).* ***Please initial _____.***

□ Mail Out to ($25 S&H due prior to shipment): _____
Accepting Physician Address

There are risks to mailing the serum, as the serum may degrade in temperature extremes, thus rendering the serum less effective. Please note that we are also not responsible for lost or damaged serums in the mail. ***Please initial _____.***

SUBCUTANEOUS IMMUNOTHERAPY (ALLERGY SHOTS) SAFETY GUIDELINES AND CONSENT

I understand that among the risks of subcutaneous immunotherapy are immediate reactions, delayed reactions, severe allergic reactions, and other reactions. I also understand that, as with every treatment, there is a possibility of unexpected complications.

The following specific risks were discussed with me:
IMMEDIATE REACTIONS: The risks of immediate allergic reactions include: large local reactions involving itching and swelling (most commonly); but also includes generalized itching, rash, hives, swelling of the lips, tongue, or throat, chest pain, chest tightness, shortness of breath, wheezing, abdominal pain, nausea, vomiting, diarrhea, palpitations, dizziness, confusion, anaphylaxis, shock, and death.

DELAYED REACTIONS: The risks of delayed allergic reactions include: large local reactions involving itching and swelling (most commonly); but also includes generalized rash and itching. Unusual reactions may include liver or kidney involvement, fevers, chills, joint pains, and ulcerations.

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SAFETY GUIDELINES

For all patients starting or on allergen immunotherapy injections, please note the following guidelines to reduce the risk of serious and life-threatening allergic reactions.

1. **BUILD-UP SCHEDULE:** During build-up period, receive injections twice a week when possible, with at least 24 hours and preferably two days between injections. No more than two injections a week.
2. **NO EXERCISE BEFORE/AFTER INJECTION:** Do not exercise for one hour before and two hours after your injection.
3. **ANTIHISTAMINES:** Take an antihistamine (i.e. Zyrtec/cetirizine, Allegra/fexofenadine, Claritin/loratadine) at least 1 hour prior to receiving your allergy injection. If antihistamines make you drowsy, you can take your antihistamine the night before your injection.
4. **OBSERVATION PERIOD:** Wait at least 30 minutes after your injection before leaving the doctor's office (mandatory). If you choose to leave earlier against medical advice, then you must sign a form attesting that you understand the risks.
5. **EPINEPHRINE AUTOINJECTOR:** Carry an up-to-date epinephrine autoinjector on days you are receiving injections.
6. **INJECTION ONLY WHEN HEALTHY:** Do not get an injection if you are sick, have a fever, cold, chest congestion, wheezing, or any symptoms of asthma or severe allergies.
7. **MINORS:** If the shot patient is under the age of 14, a parent or guardian must be present at the time of the injection.
8. **REPORT SYMPTOMS AND PREGNANCY:** Tell the nurse immediately:
    a. If after an injection you experience any generalized symptoms (such as hives, hay fever, coughing, asthma, dizziness, flushed face).
    b. If you are pregnant. Although allergy injections may be continued at maintenance dose while a person is pregnant, the dose cannot be increased during pregnancy. Please make an appointment with the doctor if you become pregnant while receiving allergy injections.
9. **REPORT DELAYED REACTIONS:** If you experience a delayed shot reaction after you leave the doctor's office, report the reaction in detail, along with any treatment you received, at your next injection.
10. **INJECTION SCHEDULE:** Your injection schedule will be modified or the frequency of your injections can be increased for reasons including but not limited to:
    a. Starting new vials
    b. Missed injections due to vacation, illness, or other reasons.
    c. Large local or systemic reactions
    d. A change in extract formula
11. **DURATION OF THERAPY:** To receive maximum benefits allergy shots should be taken all year round for 3-5 years. The effectiveness of these injections is diminished and your cost increases when the injection schedule is interrupted. Extracts expire one year after they are made. When new extracts or dilutions are required, the usual and customary fees will apply.
12. **REPORT CHANGES TO HEALTH:** It is important that you give complete and accurate medical information to the doctor and staff giving the injections— failure to do so can have serious, even life-threatening consequences.

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13. **TREATMENT CONSENT: In the unlikely event that you have a reaction, you may be treated in the clinic. Because allergic reactions can occur and worsen quickly, prompt medical treatment is critical. Treatment may include antihistamines, bronchodilators, corticosteroids and epinephrine, and can be in the form of oral, inhaled or injection medications. ***You may also be treated in a neighboring Urgent Care facility or physician with subsequent charges from that physician or department. If the reaction is severe or life-threatening, you may be transported to the nearest Emergency Department with subsequent charges from that department.**

14. **TERMINATION OF IMMUNOTHERAPY: Your safety is our top priority. If safety guidelines are disregarded, or if prompt treatment of potentially life-threatening reactions are refused, the doctor has the right to terminate immunotherapy, because in those cases the risks may outweigh the benefits. Allergen immunotherapy is one of the most beneficial treatments for allergic patients, but it has an unlikely but potentially serious risk. That risk is only minimized and mitigated when recommendations are followed and reactions are treated.**

15. **ANNUAL VISITS: You need to be seen by the doctor at least once a year in order to continue your immunotherapy prescription.**

Patient Attestation: I have had an opportunity to read, discuss and understand regarding the risks and benefits of this procedure and of the alternatives with my physician. I have had an opportunity to review and ask questions regarding the above guidelines to minimize risk of serious and life-threatening reactions. I have had an opportunity to ask about medical treatment in the case of an allergic reaction, and I consent to prompt treatment for allergic reactions. All my questions have been answered to my satisfaction, and I consent to this treatment.

Your allergy serum needs to be refilled. In order to refill your serums, we need to have your permission.
*****Serums can only be refilled if there has been a doctor's visit within one year.**

If you would like to refill your serums, and agree to the safety guidelines and treatment above, please sign and date below. If you have any questions, please call us at (801) 226-3600.

_____ Date: _____/_____/_____
Patient Signature (patient or guardian)

Relation to patient: _____ (or circle) self

Phone: (_____) _____-_____

_____ of Vials $ _____