HEDBERG ALLERGY & ASTHA CENTER, PA

REQUEST FOR INJECTIONS TO BE ADMINISTERED AT AN OUTSIDE MEDICAL FACILITY

Please complete the following if an allergy vaccine will be administered at an ***outside medical facility.***

I have read (if new patient) or reread (if established patient) all of the information about allergy injections and agree that I will not attempt to administer my vaccine to myself nor will I permit anyone who is not a licensed physician or under the supervision of a licensed physician to administer the vaccines.

I understand that payment in full must be made prior to the release of any vaccine material prior to release from this office.

Printed name of patient ____ Med Record # ___________

Patient (or a parent if minor) ____ Date ________________

Witness ____

Facility where injections will be administered: ____

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OFFICE USE ONLY – please initial and date

___________ Confirmation that patient is an active patient at this medical facility

___________ Confirmation of address that extracts are to be mailed to

Method of delivery ________ US mail (_______ Fee paid)

______ Pick Up

_________ Financial confirmation – account is in good standing (nurse to confirm with front desk/billing specialist)

_____ This form has been faxed to administering facility ________ Date __________

ONCE COMPLETE, PLEASE SCAN INTO PATIENT'S EMR