RICHARD R. ROSENTHAL, M.D., LTD.

Adult and Pediatric Allergic Disease, Asthma and Immunology

Diplomates: American Board of Allergy and Clinical Immunology

RICHARD R. ROSENTHAL, M.D., F.A.C.P. **ANA M. SAAVEDRA-DELGADO, M.D.**

RICHARD A. NICKLAS, M.D **NATALIE E. ARIAS, F.N.P.**

REQUEST TO TAKE IMMUNOTHERAPY VIALS TO ANOTHER MEDICAL FACILITY

Please complete this form if the allergy injections will be administered at a facility other than the offices of Richard Rosenthal M.D., LTD.

I have read and signed the "Informed Consent for Administration of Immunotherapy," however, I wish to have my injections administered at another medical facility (designated below), and I request that Richard Rosenthal M.D., Ltd release my vials to me for transfer to the below designated physician/facility. I understand that Richard Rosenthal M.D., Ltd has no legal or financial arrangement with the designated facility. I further understand that Richard Rosenthal M.D., Ltd 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 from the immunotherapy. I agree that I will not attempt to administer my allergy injections to myself nor will I permit anyone who is not a licensed physician, or under the direct supervision of a licensed physician, to administer the injections.

Patient Name	DOB
Patient Signature	Date Signed
Witness Signature	Date Signed

TRANSFER VACCINE TO:	FOR OFFICE USE ONLY:
Physician Name: _____	
Address: _____	
	Vials: _____ Expiration Date: _____
City/State/Zip: _____	FedEx: _____ Picked Up: _____
	Person Taking Extract: _____
Tel: _____	Instructions Sent: _____
Fax: _____	Copy in Chart:
	Re-order Sheet Included: