PROVO ALLERGY & ASTHMA CLINIC
Evan J. Matheson, M.D. Christopher L Gordon, D.O.
745 North 500 West, Provo, Utah 84601
Phone: 801-375-9292 Fax: 801-375-9290

_____ _____
Date Patient Name

_____
Pt Date of Birth

Dear Supervising Physician:

The above listed patient has requested that his/her allergy injections be given in your office, under your supervision. Allergen immunotherapy has demonstrated in controlled studies to be effective in the treatment of allergic rhinitis, asthma and Hymenoptera hypersensitivity. But the treatment is not without risk. This procedure involves the injection of materials that the patient is allergic to so there is a potential risk of reaction is involved. The American Academy of Allergy and Immunology has advised that all allergy injections be administered in a medical facility that is equipped to deal promptly with any adverse reactions such as anaphylaxis, rhinoconjunctivitis, angioedema, asthma, laryngeal edema, hypotension, and shock. **We do not recommend that allergy extracts be released for home use.**

Only a small percentage of patients receiving allergy injections experience reactions, the majority of which are local swelling, hives, rhinitis, or conjunctivitis. Asthma and shock are very rare and death is exceedingly rare. (Approximately two deaths occur yearly in the U.S out of the millions of patients being treated with immunotherapy. These historically have occurred with injections given outside of a medical facility.)

It is not necessary that you administer the injections, but your presence will be required for at least 30 minutes after the administration of the injection(s) should a reaction occur that requires treatment.

Our office will provide the allergy extracts, the injection advancement schedule with guidelines on advancement and dosing guidelines for missed injections. We will also provide a guideline for treatment of anaphylaxis and local reactions.

Thank you for your assistance. If you have any questions please feel free to call our office.

Sincerely,
Provo Allergy & Asthma Clinic

Please sign and return a copy of this form to our office if you consent to supervise the administration of allergy injections for the above named patient.

I hereby give permission for the above listed patient to receive (his/her) allergy immunotherapy injections in my office under my supervision. I further agree to administer same in accordance with the information and instructions enclosed with patients allergy extracts.

_____ _____
Physician name (please print) Date

_____ _____
Physician signature Office address

_____ _____
Office phone number