NM RMG Student Health Center at Northern Illinois University
385 Wirtz Drive DeKalb, IL 60115
(p) 815.306.2777 (f) 815.306.2778

Referring Allergist Agreement

Instructions

Read carefully prior to completing Referring Allergist Agreement. Students requesting allergy immunotherapy administration at the NM RMG SHC are required to have their referring allergist complete this form. **Students are required to establish care with a medical provider at the student health center before therapy can begin.**

NOTE: NM RMG SHC does not complete agreements for referring allergists.
NOTE: NM RMG SHC will accept only extract shipped overnight via FedEx or UPS from the patient's allergy office. Our office is closed Saturday/Sunday and all major holidays.
The US Postal Service cannot deliver overnight to this location.

- **Deadline** – Form must be completed and received in the office prior to scheduling the first appointment. This order will expire July 31st each year, and new release forms must be provided to continue immunotherapy.

Allergist Agreement – Read carefully prior to signing (must be US-licensed physician)

My patient (printed name and date of birth)_____, requests that NM RMG Student Health Center at Northern Illinois University (NM RMG SHC) administer allergy extracts provided by my office.

I agree that:

- I will provide allergen immunotherapy extracts in adequately labeled (including patient name) vials for administration at NM RMG SHC. **These extracts will be sent to NM RMG SHC via overnight shipping by FedEx or UPS from my office**. NM RMG SHC will ship extracts back to my office as needed.
- The allergen immunotherapy extracts will be prepared by individuals experienced and trained in handling allergenic products.
- I will provide maintenance concentrate that contains therapeutically effective dosing individually formulated but consistent with current guidelines as outlined within the Allergy Joint Task Force's Practice Parameter for Allergen Immunotherapy.
- If necessary, I will provide adequately labeled vials of serial dilutions of the maintenance concentrate should the patient still be undergoing buildup phase of immunotherapy.
- I acknowledge that 'off the board into one syringe' method of allergen immunotherapy preparation and administration poses risk of cross contamination. NM RMG SHC will therefore not employ this method of immunotherapy for any of its patients.
- I will provide detailed directions regarding dosage schedule for buildup phase and/or maintenance, and signed, faxed instructions on adjustments that might be necessary under the following circumstances:
  - the use of new vials;
  - if the constituents of the allergen immunotherapy extract have changed, including changes in the lot, manufacturer, vaccine type (e.g., aqueous, glycerinated, standardized, and non-standardized), and component allergens and their respective concentrations in the extract;
  - during seasonal exposure to allergens that are in the patient's allergen injection to which the patient is very sensitive; if the patient has missed injections;
  - when reactions occur to the allergen immunotherapy extract.
- I will continue to be responsible for the management of this patient's immunotherapy and for the modification of doses during therapy.
- I will reevaluate this patient at least every 6 to 12 months.
- I will be available by phone to the nurses and providers at NM RMG SHC should questions or problems arise with this patient's immunotherapy. (NM RMG SHC reserves the right to exclude non-compliant allergy practices.)
- I understand allergy injections are associated with some widely recognized risks. While most adverse reactions are local, there is a low risk of severe systemic reactions even with appropriately administered allergen immunotherapy; life-threatening and fatal reactions do occur. These systemic reactions, though rare, are unpredictable and may occur with the first injection or after a long series of injections, with no previous warning

Referring Allergist Signature:_____ **Date:** _____

Referring Allergist Printed Name: _____

After completing, signing, and dating this form, fax form: ATTN: Nurse, to 815.306.2778