

Patient _____
DOB _____ MRN _____
Date _____

Advanced Allergy & Asthma

Dr. Melissa Graham and Associates

FACILITY CHECKLIST FOR ALLERGY SHOTS AT OUTSIDE CLINIC

Thank you for agreeing to co-manage this patient during their immunotherapy injections. Please review and acknowledge the following, then return by fax to 501-420-1457.

This form must be reviewed and signed by a board-certified physician who serves as Medical Director of your facility — not by a nurse practitioner or physician assistant. A board-certified physician must confirm that facility staff are trained to recognize and treat anaphylaxis with epinephrine. If a physician is not physically present when allergy injections are given, a nurse practitioner may administer them only if under the direction of a board-certified physician who has ensured that NP's training in recognizing and treating systemic allergic reactions. **A nurse may never give allergy injections alone, without a supervising provider on-site.** If a physician assistant is the covering provider, Arkansas law requires that allergy shot coverage be explicitly stated in that PA's supervisory agreement with the responsible physician. These requirements protect patient safety and are necessary for malpractice coverage of the referring board-certified allergist.

I have reviewed the recommendations for giving allergy injections to the above patient, as provided by Advanced Allergy and Asthma, and had any related questions answered to my satisfaction. I acknowledge and agree to the following (please initial each item):

- ___ 1. I or the medical staff under my supervision will administer allergen subcutaneous immunotherapy injections for the patient named above.
- ___ 2. The patient will remain in my office for 20–30 minutes following every allergy injection to observe for adverse reactions.
- ___ 3. Either I or another licensed physician responsible for this patient will remain on-site for 20–30 minutes following administration of allergy injections, to be available to treat any adverse reaction. If a physician is not on-site, a nurse practitioner may cover only under the direction of a supervising board-certified physician who has confirmed the NP's training in recognition and treatment of systemic reactions.
- ___ 4. I have the equipment and medications required to treat anaphylaxis available in my office (injectable epinephrine, oxygen, nebulized bronchodilators, diphenhydramine, IM Benadryl, IV fluids).
- ___ 5. I or the medical staff under my supervision will completely document on the Allergy Shot Administration Record: the date, extract concentration, dose, expiration date, and injection site for each allergy injection, and any reactions occurring after injections.
- ___ 6. I or the medical staff under my supervision will not permit allergy shots to be given to a patient having active asthma symptoms.
- ___ 7. The patient's allergen extract will remain refrigerated in my office at all times.
- ___ 8. I or the medical staff under my supervision will not permit the patient to transfer the allergen extract to any other facility without permission from the prescribing board-certified allergist. If transfer is needed, I agree to contact Advanced Allergy & Asthma for instructions, or to mail the serum back for handling. I will not permit the patient to take allergy injections at home.
- ___ 9. I and my medical staff are trained in the recognition and management of both local and systemic reactions to allergen immunotherapy.
- ___ 10. I or the medical staff under my supervision will give Vial A and Vial B in opposite arms at each visit, and will alternate which arm receives Vial A versus Vial B from one visit to the next, so that the same arm does not always receive the same vial.
- ___ 11. I or the medical staff under my supervision will make every effort to ensure injections are given in the appropriate subcutaneous site, and not intramuscularly or over the posterior/triceps area of the arm — an intramuscular injection is more painful and more likely to cause a systemic reaction.

___ 12. I or the medical staff under my supervision will confirm the patient's name and date of birth before each injection, will draw up the allergy injections from the patient's own vials while the patient is present, and will show the patient their vials for identification and confirmation before administering the injections.

☐ Please check that your facility agrees to treat any signs of a systemic reaction following an allergy injection with epinephrine as soon as possible:

(a) Epinephrine 0.3 mg (0.3 cc of 1:1,000) IM for patients ≥ 60 lbs

(b) Epinephrine 0.15 mg (0.15 cc of 1:1,000) IM for patients < 60 lbs

This dose may be repeated after 5 minutes if the reaction has not subsided.

Facility _____

Advanced Allergy & Asthma Referring Physician:

Address _____

D. Melissa Graham, M.D.

**Printed Name of Physician (Medical Director) —
required, not NP/PA:**

Date: _____

**Physician Signature (board-certified MD/DO only) and
Date Signed:**

*This form must be completed and signed by a board-certified
physician. Forms signed by a nurse practitioner or physician
assistant will be returned for physician signature.*

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