Allergy & Asthma Center

of Southern Oregon, PC

Kevin W. Parks, MD Ryan B. Israelsen, MD Edward M. Kerwin, MD

Tiffany R. Smith, PA-C Joann L. Reed, MSN, NP-C

Appointments (541) 858-1003 Fax (541) 857-4499

Remix Authorization Form

I, _____ _____ _____ _____

(Patient Name) **(Parent or Legal Guardian Name)** **(Patient DOB)** **(Patient ID#)**

wish to continue with my/my child's allergy immunotherapy program and hereby authorize Allergy & Asthma Center to re-mix my/my child's allergy extract(s). I understand that I need to provide Allergy & Asthma Center with a current copy of my/my child's insurance card at the time I sign this authorization. If I do not have the insurance card in my possession at the time of signing, I understand that I will be responsible for payment of the extract(s) if the insurance information on file with Allergy & Asthma Center is incorrect or invalid.

I have read, understand and agree to the above statement:

_____ _____

(Patient/Parent or Legal Guardian Signature) **(Today's Date)**

_____ _____

(Shot Nurse/MA Signature as Witness) **(Today's Date)**

_____ _____

(Signature of MD Overseeing Immunotherapy) **(Today's Date)**
Dr. Kerwin / Dr. Parks / Dr. Israelsen

Last Injection:

DATE	VIAL (A/B/C)	CONC.	AMOUNT	GIVEN BY	Reason for Remix

Office where shots are given: **MEDFORD** **GRANTS PASS** **KLAMATH FALLS** **ROSEBURG**
(please circle correct office)

ASHLAND **OUTSIDE OFFICE: _____**
Name of Clinic

***PLEASE ATTACH A COPY OF PATIENT'S <u>CURRENT INSURANCE CARD</u>**

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Checklist and Approval for Remix of Allergy Serum

_____	_____	_____
(Patient Name)	**(Patient DOB)**	**(Patient ID#)**

Date of Last Office Visit: _____ **Date Patient Started Immunotherapy: _____**

Steps 1-3 to be completed by Shot MA with patient:

1. **Current Medication Use: (mark all)**
   - ☐ Medication use for optimal control discussed with patient
   - ☐ Frequency of shots? Circle one: Q weekly Q 2 weeks Q monthly Other
   - ☐ Which antihistamines are used on shot days? _____
2. **Reactions to Injections: (mark one)**
   - ☐ No significant reactions
   - ☐ Local reactions (dime sized swelling or larger) in the past month
   - ☐ Systemic reactions (needed Epinephrine in the last year)
   - ☐ Other:_____
3. **Patient's Response to Immunotherapy: (mark all that apply)**
   - ☐ Much better- nose allergies- occasional antihistamines
   - ☐ Much better- asthma symptoms 2 days weekly or less
   - ☐ Much better- skin eczema rash infrequent (<1 time monthly)
   - ☐ Allergy symptoms remain active
   - ☐ Allergy symptoms unchanged
   - ☐ Worst Seasonal Symptoms: Circle: Spring Summer Fall Winter

MD Steps 4-7 to be completed by AAC medical doctor overseeing immunotherapy:

4. **Antigen Content of Vials: (mark all that apply)**
   - ☐ Antigen mix is still optimal for current medical status
   - ☐ Antigen content of vials needs to be adjusted (optional)
   - ☐ Other: _____
5. **Injections are: (mark one)**
   - ☐ Continued as patient getting ongoing symptom improvement
   - ☐ Patient okay to graduate (>4-5 years immunotherapy done)
   - ☐ Patient needs long term immunotherapy (>5 years) marked ongoing symptoms and ongoing marked exposure
   - ☐ Patient needs allergy reevaluation
   - ☐ Other: _____
6. ☐ **I have considered all of these in making the decision to continue immunotherapy.**
7. ☐ **Medical doctor overseeing patient needs to sign Remix Authorization Form on next page.**

_____	_____
(Signature of Medical Doctor Overseeing Immunotherapy)	**(Today's Date)**

Dr. Kerwin / Dr. Parks / Dr. Israelsen