



BIOLOGIC INJECTIONS TRANSFER FORM – OUTSIDE OF ALABAMA ALLERGY & ASTHMA CENTER

Alabama Allergy & Asthma Center allows your biologic injections to be transferred to another office or practice under the agreed to supervision of a licensed physician. Please sign and fully complete the form below to transfer your injections to another facility.

- I have read and signed the consent for the *Administration of Biologic Injections*.
- I understand that I will receive injections and use all off my biologic vials currently on hand at Alabama Allergy & Asthma Center prior to transferring to the facility listed below. I also understand vials will not be transferred until this form is received and signed by the supervising physician designated below.
- I wish to have my injections administered at the medical facility below. I have confirmed that the staff is willing and able to provide biologic injections and able to recognize and treat immediate or delayed adverse reactions that may result from the injections. I agree that I will not attempt to administer biologic injections to myself, nor will I permit anyone who is not a licensed physician or under the supervision of a licensed physician, to administer my biologic injections. I further agree to notify this office if I transfer my care and or vials to any medical facility other than the one I designate below.
- I understand that I am responsible for changing the shipping address with my specialty pharmacy to that of the facility below. I also understand that I may call Alabama Allergy & Asthma Center at any time with questions or if issues develop, and that I may return to this office for the administration of my injections if needed.

Patient Name: _____

Patient Date of Birth: _____

Parent/ Guardian Name (If Applicable): _____

Patient or Parent/Guardian Signature: _____ **Date:** _____

I agree to administer the biologic injections for this patient in my office. I am aware of the storage requirements for the biologic and agree to receive and appropriately store the drug. I also agree to monitor the patient for the appropriate wait time after each injection.

Supervising Physician Signature: _____ **Date:** _____

Supervising Physician Name: _____

Street Address: _____

City/ State/ Zip: _____

Phone: _____

**THIS FORM SHOULD BE COMPLETED AND FAXED TO THE ATTENTION OF BIOLOGICS COORDINATOR,
AMY PALMER, AT (205)870-1621.**

IF YOU HAVE ANY QUESTIONS PLEASE CALL AMY DIRECTLY AT 205-209-4163.