

TRANSMISSION VERIFICATION REPORT

TIME : 11/04/2020 16:10
NAME : AUM
FAX : 3342443396
TEL :
SER.# : BROD8J659256

DATE, TIME	11/04 16:10
FAX NO./NAME	913345280079
DURATION	00:00:00
PAGE(S)	00
RESULT	BUSY
MODE	STANDARD

BUSY: BUSY/NO RESPONSE

Refaxed 5 times on
11/05/20. Unable to
fax. Patient picked-
up forms to send directly.
-Bj.

TRANSMISSION VERIFICATION REPORT

TIME : 10/14/2020 14:15
NAME : AUM
FAX : 3342443396
TEL :
SER.# : BROD8J659256

DATE, TIME
FAX NO./NAME
DURATION
PAGE(S)
RESULT
MODE

10/14 14:14
9133452800799741319
00:01:26
04
OK
STANDARD

P.O. Box 244023
Montgomery, AL 36124
Phone: 334-244-3281
Fax: 334-244-3396



AUBURN UNIVERSITY
AT MONTGOMERY

WARHAWK HEALTH SERVICES

Attn: East Alabama Allergy & Asthma
To: **From:** Lindsey Barton, CRNP
Fax: 334-528-0079 **Pages:** 4
Phone: 334-528-0078 **Date:** 10/14/2020
Re: T. Bottoms D.O.B. 6/21/77 **cc:**
☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Comments:

IMPORTANT: This facsimile transmission contains confidential information, some or all of which may be protected health information as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule. This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this facsimile transmission to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone (number listed above) to arrange the return or destruction of the information and all copies.



1925 E Glenn Ave. Auburn, AL 36830
Phone (334) 528-0078
FAX (334) 528-0079
www.EAAllergy.com

Patient Request for Allergen Immunotherapy at Outside Facility

DATE: 10/14/2020

PATIENT: Tiffany Bottoms

DOB: 6/21/1977

Dear Lindsey Barton, CRNP

The above named patient wishes to receive his/her allergen immunotherapy injections in your clinic. Please complete this form and return to East Alabama Allergy and Asthma at the FAX number above. By signing this document, your office agrees that this patient is to receive his/her immunotherapy injections under your supervision and that your office has the means to treat adverse reactions to allergy injections, if one were to occur. We appreciate your assistance in helping us provide quality healthcare for this patient.

John W. Tole, D.O.

Board Certified Allergy and Clinical Immunology

Please answer the following:

Is there a physician or physician extender available at all times when allergy shots are given? ☒ Yes ☐ No

Is there a physician or physician extender available while the patient remains in clinic for the 30-minute waiting period? ☒ Yes ☐ No

Does your clinic already give allergy shots to other patients? ☒ Yes ☐ No

Does your clinic have the capacity to manage systemic reactions to allergy injections? ☒ Yes ☐ No

Please check which items you have available:

☒ Epinephrine ☒ Antihistamine ☒ Oxygen ☒ Albuterol solution for nebulizer ☒ IV Fluids

I hereby give permission for the above named patient to receive allergy immunotherapy injections under my supervision and the injections will be done in a facility that has the means to treat adverse reactions, if one were to occur. Our office will follow the *Instructions for Medical Offices Administering Immunotherapy*, which will be provided with the patient's extract vial(s). We will notify East Alabama Allergy and Asthma if a patient has a systemic reaction to an injection.

Provider's Name: Lindsey Barton, CRNP

Provider's Signature: [Signature]

Nurse's Name: Amy Morris, RN

Clinic: AUM Warhawk Health Services

Address: 7461 EAST DR Suite 102

Phone: (334) 244-3281

FAX: (334) 244-3396

Date: 10/14/2020



East Alabama Allergy and Asthma, PLLC

1925 E Glenn Ave., Auburn, AL 36830

Phone (334) 528-0078

FAX (334) 528-0079

www.EAAllergy.com

Request for Administration of Allergy Injections at an Outside Medical Facility

Please complete this form if the allergy extract will be administered at a medical facility other than East Alabama Allergy and Asthma.

I have read and signed the *Consent for Administration of Allergy Injections*. However, I wish to have my injections administered at the medical facility designated below, and I request that my extract vial(s), along with instructions for administration of the injections, be forwarded to the medical facility designated below. It is my responsibility to make certain that the facility and its staff are willing and able to provide allergy immunotherapy, and able to recognize and treat immediate or delayed adverse reactions that may result from the immunotherapy. I agree that I will not attempt to administer my extract injections to myself, nor will I permit anyone who is not a licensed physician, or under the supervision of a licensed physician, to administer the extract injections. I further agree to notify East Alabama Allergy and Asthma if I transfer my immunotherapy extract vial(s) to any medical facility other than the one designated below. I understand that I may call this office at any time if questions or problems develop, and that it may be necessary for me to return to this Allergy office for continued administration of my injections in a safe environment.

Tiffany Bottoms

Printed Name of Immunotherapy Patient

Tiffany Bottoms

Patient Signature (or Legal Guardian)

SMJ

Witness

10-14-20

Date Signed

10/14/20

Date Signed

NAME, ADDRESS, AND PHONE NUMBER OF THE PHYSICIAN WHO WILL SUPERVISE THE ADMINISTRATION OF THE ALLERGY INJECTIONS:

Name of Medical Facility that will be administering shot(s): Warhawk Clinic @ AUMPhysician Name: Lindsey Barton, CRNP studenthealthservices@
aum.edu

Street Address: _____

City/State/Zip: Montgomery, ALPhone: 334 244 3281Fax 334 244 3396

For EAAA Office Use

Approved: _____

Allergist's Signature

Dr. John W. Tole

Date Signed _____

PLEASE FAX SIGNED FORM TO: 334-528-0079
or EMAIL: ShotClinic@EAAllergy.com

**East Alabama
Allergy and Asthma, PLLC**

1925 E Glenn Ave, Auburn AL 36830

Phone (334) 528-0083

FAX (334) 528-0079

stephanie@eaallergy.com

To: Warhawk Clinic**From:** Stephanie**Fax:** 334-244-3396**Pages:** 3 including cover**Phone:** 334-244-3281**Date:** 10/14/20**Re:** Consent Form**CC:**☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply :**COMMENTS:**

Please have your doctor sign the form stating they will be getting the shots at your office which has a check off list so we know how prepared your clinic is for giving shots and treating a reaction, if one were to occur.

Please fill out the consent form and fax or email back to us and we will overnight the patients vials with a packet of information explaining the shot process.

If you have any questions, please give me a call!

Thank you,
Stephanie Tapley
Shot Clinic Manager
334-528-0083