San Francisco
Allergy | Asthma | Immunology

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Vial Transfer Request

Please complete this form and upload it via MyChart or drop it off at the office.

Patient Name: _____ Date of Birth _____

I request the transfer of my _____ to the following location:

- ❑ Union Square: 450 Sutter St., Suite 1139
- ❑ Pacific Heights: 2100 Webster St., Suite 202
- ❑ Castro: 45 Castro St., Suite 325
- ❑ San Rafael: 899 Northgate Dr., Suite 110

My last shot appointment at my current location is _____. By signing below, I authorize the transport of my items. I have been informed that the transfer can take up to two weeks and I will be contacted after my items have been transported to schedule my first shot appointment at the new location.

Patient Signature: _____ Date:_____

For Office Use

- ❑ Above information was reviewed with patient
- ❑ Transfer information added on Inter-Site Transfer Spreadsheet
- ❑ SCIT record scanned into Media Manager
- ❑ Back-up autoinjector set aside for transfer (if available)
- ❑ Vials placed in the Fridge Outbox
- ❑ Messaged MA pool at new location to notify of transfer