San Francisco
Allergy | Asthma | Immunology
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# Vial Transfer Request Form

**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 allergy shot vials to the following location:

- ❑ Union Square: 450 Sutter St., Suite 1139
- ❑ Pacific Heights: 2100 Webster St., Suite 202
- ❑ Duboce Triangle: 45 Castro St., Suite 325

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