



Attachment D: Physician Letter - FOH-23 Form
Allergen Immunotherapy, Other Medications and Treatments

Dear Doctor:

Your patient _____ has requested that the Federal Occupational Health (FOH), Occupational Health Center (OHC) located at his/her worksite give allergen immunotherapy, medications or treatments that have been prescribed by you.

- The OHC is willing to perform this service for you and your patient if you feel it can be done safely given the circumstances under which we operate. **Before giving your approval for your patient to receive treatment in the OHC, please consider the following:**
- The OHC nurse will be providing allergen immunotherapy, medication or treatment under the direction of the employee's private physician. This setting is an inappropriate source for care if there are any treatments or medications which should be given or (withheld) depending on recent laboratory results (i.e. leukocyte counts) or if there is reasonable anticipation of acute reaction after the treatment is provided.
- The OHC may have only two health professionals with current CPR training.
- The OHC is equipped with 1:1000 aqueous epinephrine, oxygen, and diphenhydramine HCL which may be used in the event of an adverse reaction to the medication.
- Our OHC **does not** have equipment for intubation, cardioversion, tracheotomy, blood gas analysis, intravenous fluids, or intracardiac injection.

Please complete the "Physician's Statement" section below indicating you have read the Attachment C: "Prescribing Physician Information and this letter.

FOH Telephone _____

Physician's Statement

I have carefully read the "Prescribing Physician Information" and this Physician Letter, and believe the above named patient may safely receive the specified allergen immunotherapy, medications or treatment in a FOH health center.

_____ YES* _____ NO

Physician's Name (Print) _____

Physician's Signature _____

Phone Number _____ Date _____

*If you marked Yes, you need to complete and sign the enclosed "Physician Treatment Orders" Attachment E: FOH-24 Form. If an alternative treatment order form is used, it must include the following information:

<ul style="list-style-type: none">• Employee's name• Exact name of the medication• Interval of administration• Medication dosage• Reactions that may occur and measure to be taken in the event of a reaction• Route of administration	<ul style="list-style-type: none">• FOH center address• Date of employee's next appointment at private physician• Physician telephone number• Physician name and signature• Method for handling first injection of multidose vials
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