Date: [Insert Date]

To: [Primary Care Physician Name]
Address: [Clinic Address]
Fax/Email: [Contact Information]

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
ID Number: [Patient ID]

Subject: Discharge to Maintenance Phase for Subcutaneous Immunotherapy (SCIT)

Dear Dr. [PCP Last Name],

The above-named patient has successfully completed the "Build-up Phase" of their Subcutaneous Immunotherapy (SCIT) for the treatment of [Specify Allergies, e.g., Allergic Rhinitis / Asthma] under our supervision.

The patient has now reached their **Maintenance Dose** and is stable. They are being discharged to your clinic to continue their maintenance injections according to the following schedule:

Maintenance Protocol:

- **Allergen Extract:** [Specific Extract Name/Concentration]
- **Maintenance Dose Volume:** [e.g., 0.5 mL]
- **Vial Color/Number:** [e.g., Red Vial / Maintenance Vial]
- **Frequency:** Every [Number] weeks (Current interval: [Interval])
- **Expiration Date of Current Vial:** [Date]

Safety Instructions:

- Injections must be administered subcutaneously (not intramuscularly).
- Patients must be observed for at least 30 minutes following every injection.
- Epinephrine must be available on-site during administration.
- Do not administer if the patient is febrile, experiencing an asthma exacerbation, or has a significantly low Peak Flow.

Adjustment for Missed Doses:

If a dose is missed by [Number] days/weeks, please refer to the attached dose adjustment schedule or contact our office for guidance before proceeding.

The patient is scheduled for a follow-up evaluation in our specialist clinic on [Date]. Please contact us at [Phone Number] if the patient experiences any systemic reactions or if you have questions regarding the protocol.

Sincerely,

[Physician Signature]
[Physician Name, Title]
[Department/Clinic Name]