

ORAL IMMUNOTHERAPY PHYSICIAN REVIEW SHEET

[Patient Label / Sticker if available]

Patient Name: _____

Food: _____

CLINICAL ATTESTATION (required):

By signing below, the physician certifies the following:

- Protocol review:** I have personally reviewed the food protein concentration(s), doses and calculations in the attached protocol, and confirm they are clinically appropriate for the patient.
- Patient-facing material review:** I have reviewed the handout and patient education content, and confirm they are applicable and appropriate for the patient.
- Informed Consent:** I have obtained informed consent from the patient/caregiver(s), which included a discussion on the benefits and risks of OIT and alternative options.

Physician Signature

Date (D/M/Y)

Printed Name / Stamp

GENERATED CONTENT WARNING: This document was created using an open-source calculation tool. This tool does not exercise clinical judgment. This document is NOT valid until reviewed and signed by a licensed physician.

Any use of this document without direct physician supervision is strictly prohibited.