ORAL IMMUNOTHERAPY
PHYSICIAN REVIEW SHEET

[Patient Label / Sticker if available]	**Patient Name:** _____ **Food:** _____

CLINICAL ATTESTATION (required):

By signing below, the physician certifies the following:

1. **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.
2. **Patient-facing material review:** I have reviewed the handout and patient education content, and confirm they are applicable and appropriate for the patient.
3. **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