

# DALLAS ALLERGY & ASTHMA CENTER

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## ALLERGY EXTRACT RE-ORDER FORM (Mail Out)

**An office visit (AT LEAST ONCE A YEAR) is required to continue current Immunotherapy and for the renewal of any allergy/asthma medications.**

To re-order extract for allergy injections please complete all information below and mail or fax both sides of this form, **at least THREE WEEKS before new extract is needed. TELEPHONE ORDERS WILL NOT BE ACCEPTED!!!!!!!!!!** Thank you for your cooperation to assure a continuous schedule. When faxing, please include **FRONT AND BACK** of this form.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Current Insurance: \_\_\_\_\_ Insurance ID # \_\_\_\_\_

I authorize Dallas Allergy & Asthma Center to order and prepare my allergy extract and understand my account will be charged and insurance filed for these vials. I also understand that I am responsible for the payment of these charges should insurance not cover them. With this knowledge, I request the vials to be ordered and prepared for me.

(\* Required) Signature of Patient/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_

Vial 1 needed:      1:100    1:10    FS

**Please circle the vial(s) you need**

Vial 2 needed:      1:100    1:10    FS

Injections are given every \_\_\_\_\_ days.    Volume of last injection was \_\_\_\_\_ ml.

Is the patient having any reactions to the injections?    Yes    No

If yes, please describe \_\_\_\_\_

(\* Required) Facility where patient is receiving injections: \_\_\_\_\_

Address for mailing extract: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime phone number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

(\* Required) Name of medical personal administering injections: \_\_\_\_\_

