

Institute for Asthma & Allergy, P.C.

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ALLERGY SERUM REQUEST FORM

Patient Name: _____ D.O.B _____
(Please print)

Vials requested: _____ Date _____

- In order for us to properly process your allergy serum refill request, please complete the following forms.
 - Allergy Serum Request Form (signature required).
 - A copy of your current allergy injection records showing the dates and dosages of your injections.
*We **CAN NOT** process the refill request unless records are provided!
 - A current Copy of your valid insurance card.
 - A valid referral, if applies.
- "Allergy Serum request Form" must be completed/signed by patient/parent and returned at **LEAST TWO WEEKS** in advance of need.

**Please schedule an appointment, so that you may
start your serum refill!**

- This form may be mailed to:

Institute for Asthma & Allergy, P.C.
2 Wisconsin Circle, #250
Chevy Chase, Maryland 20815
or
Fax: 301-907-7910

- The first injection from any new vial of serum **must be given in our office**. Please call first to ensure that your allergy extract refill is ready for your appointment.
- I understand that an allergy serum is being prepared especially for me, and that I will be billed for this serum prescription.

Patient Signature (or parent if patient is a minor)

Contact #

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