Institute for Asthma & Allergy, P.C.

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ALLERGY SERUM REQUEST FORM

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

Vials requested: _____ Date _____

5. In order for us to properly process your allergy serum refill request, please complete the following forms.
   1. Allergy Serum Request Form (signature required).
   2. 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!
   3. A current Copy of your valid insurance card.
   4. A valid referral, if applies.
2. "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!

3. This form may be mailed to:

Institute for Asthma & Allergy, P.C.
11002 Veirs Mill Road, #414
Wheaton, Maryland 20902
or
Fax: 301-962-9585

6. 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.

5. 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 # Contact #