Institute for Asthma and Allergy, P.C.

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ALLERGY SERUM REQUEST

Patient's Name: ______________________________ D.O.B. ____/_____/______
(PLEASE PRINT)

Vials requested: ______________________________ Date: ____/_____/______

1. In order for us to properly process your allergy serum refill request, please complete the following:
    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 3 WEEKS in advance of need.

*******Effective January 2019******
Every patient must schedule an appointment to receive the first injection from their serum refill vials!

3. This form may be mailed to:

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

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

____
Patient's Signature (or if patient is a minor)

____
Contact Number