ALLERGY AND ASTHMA CARE, P.A.
12000 ELM CREEK BLVD. #200
MAPLE GROVE, MN 55369
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ALLERGEN VACCINE ORDER FORM

(Please fax the injection records along with this form and allow 2-3 weeks for delivery.
Please note we do require verbal authorization/insurance verification from patient before processing any refill.
This may delay the delivery process; make sure you have at least 1dose left in vial when ordering)

Date: _____
Patient Name: _____
DOB: _____
Allergist: _____

1. Allergen Content: _____
Last Injection Date: _____ Last Dose: _____
Vial Concentration (Color) please circle: 1:10,000 (Silver) 1:1000 (Green) 1:100 (Blue) 1:10 (Yellow) 1:1 (Red)

Top Dose: _____ Week Intervals: _____
Vial Concentration (Color) please circle: 1:10,000 (Silver) 1:1000 (Green) 1:100 (Blue) 1:10 (Yellow) 1:1 (Red)

2. Allergen Content: _____
Last Injection Date: _____ Last Dose: _____
Vial Concentration (Color) please circle: 1:10,000 (Silver) 1:1000 (Green) 1:100 (Blue) 1:10 (Yellow) 1:1 (Red)

Top Dose: _____ Week Intervals: _____
Vial Concentration (Color) please circle: 1:10,000 (Silver) 1:1000 (Green) 1:100 (Blue) 1:10 (Yellow) 1:1 (Red)

3. Allergen Content: _____
Last Injection Date: _____ Last Dose: _____
Vial Concentration (Color) please circle: 1:10,000 (Silver) 1:1000 (Green) 1:100 (Blue) 1:10 (Yellow) 1:1 (Red)

Top Dose: _____ Week Intervals: _____
Vial Concentration (Color) please circle: 1:10,000 (Silver) 1:1000 (Green) 1:100 (Blue) 1:10 (Yellow) 1:1 (Red)

MAIL TO:

Name:		
Attention to:		
Address:		
City:	State:	Zip Code:

Person ordering: _____

Telephone: _____