MAIL OUT EXTRACT REORDER FORM

Mixing Department: 790 Church Street
Suite 150 Marietta, GA 30060
(770) 579-8979 office (770) 579-8603 fax

Check one:

- ☐ AL (770) 475-0807
- ☐ AU (770) 948-3774
- ☐ BH (404) 351-5711
- ☐ CN (770) 720-8000
- ☐ DV (770) 942-7696
- ☐ EC (770) 973-5578
- ☐ FV (770) 461-6400
- ☐ HM (678) 801-4838
- ☐ JC (770) 495-6258
- ☐ KE (770) 427-1471
- ☐ LV (770) 995-1537
- ☐ NL (770) 491-9300
- ☐ RO (706) 234-0094
- ☐ SB (770) 506-0087
- ☐ SN (678) 280-0202
- ☐ SS (404) 252-4207
- ☐ WS (770) 924-0096

To request a refill of your allergy extract, complete the following information. The patient, parent or guardian must sign the request and mail or fax to the address above no less than **3 weeks** in **advance** of the date the extract will be required. (For your safety, telephone orders are not accepted.)

Patient's Full LEGAL Name: ______________________________ DOB: __________

Acct. #: ______________________________ Physician: ____________________

Mail Extract To (Name) ______________________________ Phone # ________________

Address: ____

Street City State Zip

During immunotherapy, your physician may need to dilute your extract for medical reason, this will be done at no extra charge to you. However, if dilutions are needed as a result of you falling behind on your immunotherapy schedule, you will be responsible for the cost.

BY SIGNING THIS FORM, YOU ARE AUTHORIZING THE REFILL OF YOU OR YOUR CHILD'S EXTRACT AND ARE AGREEING TO PAY FOR THE REFILL UPON BEING BILLED.

______________________________ ______________________________

Signature (patient, parent or guardian) Date

Type and Concentration of Extract: ______________________________ Dosage: __________________

______________________________ Dosage: __________________

______________________________ Dosage: __________________

______________________________ Dosage: __________________

Date of Last Injection(s): ______________________________ Interval of Injections: __________

ALWAYS check date on extract vial-NEVER use expired extract

SEE ATTACHED SHEET(S) FOR SCHEDULE AND THERAPEUTIC INSTRUCTIONS