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Institute for Asthma & Allergy, P.C.

11002 Veirs Mill Road, #414, Wheaton, Maryland 20902
301-962-5800 Fax: 301-962-9585
2 Wisconsin Circle, #250, Chevy Chase, Maryland 20815
301-986-9262 Fax: 301-907-7910

ALLERGY SERUM REQUEST FORM

Patient 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 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. The Patient Information form (completed)
    4. Policy Questionnaire (completed)

2. "Allergy Serum Request Form" should be completed / signed by the 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.
2 Wisconsin Circle, #250
Chevy Chase, Maryland 20815
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 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 the serum prescription.

Patient Signature (or parent if patient is a minor)

_____ _____
Home Phone Number Work Phone Number