Advanced Allergy & Asthma
Dr. Melissa Graham and Associates

FOR OFFICE USE ONLY.
_____
_____
_____
_____

If your insurance has changed, or if your referral has expired, please call our office at 501-420-1085. Processing of your extract order may be delayed if your insurance information or referral is not correct. This form must be filled out in its entirety.

PLEASE ALLOW UP TO 2 WEEKS

ALLERGY EXTRACT ORDER FORM

NO TELEPHONE ORDERS, PLEASE/ FAX ORDERS to 501-420-1457

DATE OF REQUEST: _____ PATIENT #: _____

PATIENT NAME: _____ DOB: _____

ADDRESS:_____CITY_____ST_____ZIP_____

HOME PHONE_____WORK PHONE_____CELL_____

INSURANCE CO_____ID#_____GROUP#_____

We will need the following information:

Date of last injection? _____

Dose of last injection? VIAL A _____cc VIAL B _____cc

Dilution of last injection? VIAL A _____ VIAL B _____

Color of Cap (Circle): Red Yellow Blue Green Silver

Expiration date: VIAL A _____ VIAL B _____

Circle which applies to your dose: Building or Maintenance

Interval between injections? 1 week 2 weeks 3 weeks 4 weeks

How are injections being tolerated? _____

What dilution extract is needed at this time? _____

1:100	1:1000	1:10,000	1:100,000	1:1,000,000
Red	Yellow	Blue	Green	Silver

MD's office where allergy injection(s) are given: _____

Nurse who administers AIs? _____ MD telephone #: _____

Are you having any reactions to your injections? If yes: (Circle which apply)

<3 inches of redness & swelling >3 inches of redness & swelling other_____

List all medications you are currently taking: **NOTE: ALLERGY INJECTIONS SHOULD NOT BE GIVEN IF PT IS TAKING A BETA BLOCKER MEDICATION.**

_____

Where should we mail your extract?

Address: _____

****PLEASE ATTACH PT DOSAGE RECORDS FOR THE PREVIOUS 3 MONTHS****

NAME OF PERSON ORDERING EXTRACT: _____ PH#_____

Signature of patient/guarantor approving reorder: _____