



ALLERGY EXTRACT REORDER FORM

THIS FORM MUST BE COMPLETED BEFORE VIALS ARE MIXED.

Patient Name: _____ DOB: _____

Date of Last Injection/Drop(s): _____

Female Patient: Are you pregnant? _____ If yes, please contact our office.

List Current Medications: _____

Pharmacy Used: _____

Are you having any problems or reactions with your injections? _____

Have your allergy symptoms improved? Yes or No (Please explain if no) _____

Epinephrine Autoinjector Expiration Date: _____ Not applicable per my physician

I understand that epinephrine should be used immediately for any signs or symptoms of anaphylaxis, and that delaying treatment may be dangerous. When in doubt, I should use epinephrine and seek emergency medical care. _____ (Initials)

I have received training on the signs and symptoms of anaphylaxis. _____ (Initials)

I have received training on how to use my epinephrine administration device. _____ (Initials)

I wish to continue allergy injections/sublingual drops. I understand that the allergy extract that I am ordering is prepared especially for me. It cannot be used for any other person. If I choose not to use this vial/bottle of extract, I realize that I am still financially responsible for it. I, therefore, authorize the office of ENT & Allergy Specialists to bill my insurance for this extract. For sublingual immunotherapy, I authorize the office to bill me for the extract.

Print Name: _____

Signature: _____

Date: _____

Phone: (859) 781-4900 Fax: (859) 572-3036 Email: allergy@nkyent.com

You may fax, email or hand deliver this order form to our office.

If the allergy department does not contact you within one to two weeks from the date this form is returned to our office, please inquire to see if your extract is ready.

Disclaimer: Please be aware that sending information via email is not a secure method of communication unless the sender encrypts the email.