(Office Only) MRN: ______________________

Doctor: (circle one) **JACOBS** or **BURKHARDT** or **BABBEL**

PATIENT NAME: ______________________

DOB: ___/___/_____ **AGE:** _____ **SEX: M / F**

DATE: ___/___/_______

SUBLINGUAL IMMUNOTHERAPY (ALLERGY DROPS) SERUM REFILL FORM

Payment to be made at the time of order.
Please allow 2 weeks for serum refills and delivery.

Bottle: ________ Dilution: ________________ Dose: _________

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Bottle: ________ Dilution: ________________ Dose: _________

Bottle: ________ Dilution: ________________ Dose: _________

Bottle: ________ Dilution: ________________ Dose: _________

Number of Vials: _________ $150/vial per month

Number of Months: _________ (6 vials maximum)

Charge: $ ______________

Delivery:
☐ Office Pick-up ☐ Mail Out to ($25 S&H/month): ______________________________
Address

Signature: _________________________________ Date: _____/______/________

Phone: (______) _______-___________

Revere Health Allergy, Asthma & Immunology ● Phone (801) 226-3600 ● Fax (801) 224-3811
Orem: 454 W 800 N, Orem, UT 84057
Spanish Fork: 972 N 600 E, Spanish Fork, UT 84660

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