



(Office Only) MRN: _____

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

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: _____
Bottle: _____ Dilution: _____ Dose: _____
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/bottle S&H/month): _____
Address

Signature: _____ Date: ___/___/___

Phone: (____) _____ - _____