Revere Health
Allergy, Asthma & Immunology

(Office Only) MRN: _____

Doctor: **JACOBS** or **BURKHARDT** or **BABBEL**
(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: _____

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Bottle: _____ Dilution: _____ Dose: _____

Bottle: _____ Dilution: _____ Dose: _____

Bottle: _____ Dilution: _____ Dose: _____

Number of Vials: _____ $180/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: (_____) _____-_____