

**Adult & Pediatric
Allergy Center of Northern Virginia**

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NEW EXTRACT ORDER

New Extract For: _____ DOB: _____
(Please print patient's name)

Address: _____

Phone Number: _____

Current Insurance: _____

Number of Sets: _____

Please mail 2-3 weeks in advance of the date extract will be required to:

Adult and Pediatric Allergy Center of Northern Virginia
100 Elden Street, Suite 10
Herndon, VA 20170

OR FAX to: 703-478-6612

Please include a copy of the referral if you are with an HMO. If you need a referral you are responsible for obtaining the referral for allergy sera and shots.

Patient's Signature _____ Date: _____
(or parent/guardian if patient is a minor)

No orders can be filled without patient's signature.

Please call to schedule shot appointment. We do not call you to schedule this appointment.

Office use only:

Date order form rec'd: _____ Shot appt: _____