

*Adult & Pediatric  
Allergy Center of Northern Virginia*

Telephone: 703-689-2000  
Fax: 703-478-6612

100 Elden Street, Suite 10  
Herndon, Virginia 20170

**REFILLS OR DILUTIONS**  
**ORDER FORM**

Please Refill Extract For: \_\_\_\_\_ DOB: \_\_\_\_\_  
(Please print patient's name)

Address: \_\_\_\_\_ Check here if new address \_\_\_\_\_

Phone Number: \_\_\_\_\_ Check here if new phone # \_\_\_\_\_

Current Insurance: \_\_\_\_\_ Check here if new insurance \_\_\_\_\_

	Vial	Content	Current Concentration	Current Dosages
<input type="checkbox"/>	1.	_____	_____	_____
<input type="checkbox"/>	2.	_____	_____	_____
<input type="checkbox"/>	3.	_____	_____	_____
<input type="checkbox"/>	4.	_____	_____	_____

Interval of injections: \_\_\_\_\_

Date of last injection: \_\_\_\_\_

Please note here if dilutions are needed: \_\_\_\_\_

Date of last follow-up with one of our providers: \_\_\_\_\_

Describe any reactions to injections: \_\_\_\_\_

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 a shot appointment. We do not call you to schedule this appointment.**

Office use only:

Date order form rec'd: \_\_\_\_\_ Shot appt: \_\_\_\_\_