Adult & Pediatric
Allergy Center of Northern Virginia
Donna L. Schuster, M.D.
Ngoc Tran Vu, M.D.
Diplomates American Board of Allergy and Immunology
Anna Lisowski, F.N.P.

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
☐	1. _____	_____	_____	_____
☐	2. _____	_____	_____	_____
☐	3. _____	_____	_____	_____
☐	4. _____	_____	_____	_____

Interval of injections:_____
Date of last injection:_____
Please note here if dilutions are needed:_____
Date of last follow-up with Dr. Schuster, Dr. Vu, or Anna Lisowski, F.N.P.: _____
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: _____