AUTHORIZATION TO REFILL/ PREPARE ALLERGEN EXTRACT

Name of person completing this form ______________________________(patient or parent)

I hereby authorize the Oklahoma Institute of Allergy & Asthma to prepare allergen extract for allergy immunotherapy for my self or my dependent.

I understand that office will work with me in filing charges with my insurance carrier. I will be responsible for payment of charges not covered by my insurance. (For REFILLS the charge (Date of billing) for the extract does not always coincide with the preparation. Depends on the frequency/ amount of volume of injections.)

For all extract being mailed out to the patient or facility administering the injections, there will be a postage fee (equivalent to our cost) charged to your account. OIAA will not be held responsible for the loss/ damage of mailed serum. All questions/ concerns regarding allergen extract have been addressed & answered to my satisfaction.

★ 1.) We prefer pt to directly pick up serum 2.) If mailed- all mail outs occur on Mondays only

______________________	______________________
Patient Name (Please Print)	**Patient Date of Birth**
______________________	______________________
Signature of Pt/ Guardian	**Todays Date**
______________________	______________________
Daytime Telephone #	**PA/ MD**
______________________	______________________
Address	**Insurance Company**
______________________	______________________
City/ State/ Zip	**Witness**

★ FOR OFFICE USE ONLY ★

FOR REFILLS ONLY: Please mail or fax the following completed form to OIAA when your vial is half empty for refill.

Out of serum refill concentrate (within 3-5 years of treatment period)

Pt. Behind (illness, noncompliance, uncontrolled asthma, etc..)
***Make new dilution ☐ 1:10☐ 1:100 ☐ 1:1000**

New skin test/ New sensitivities/ Pt clinically not controlled (asthma or allergy)/ Revised extract order.

Number of vials ☐ 1 ☐ 2 ☐ 3 ☐ 10cc Vials ☐ 5cc Vials

Rush Set ☐ 5 dilutions

__________ # of Doses

Cluster Set ☐ 5 dilutions

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