Authorization to refill/prepare allergen extract	
Patient Name:	Date of Birth:
Address:	City,State,Zip:
Cell Number:	Insurance:
OIAA Provider:	Witness:
• I hereby authorize Oklahoma Institute of Allergy Asthma & Immunology (OIAAI) to prepare allergen extract for allergy immune therapy for patient listed above. • **I understand that OIAAI requires payment of serum prior to it being remixed.** • I understand that OIAAI files charges with my insurance carrier and that I am responsible for payment of all charges not covered by my insurance. • Extract that is mailed to a patient or facility administering the injections require postage payment in advance of shipment. I understand that OIAAI will not be held responsible for any loss/damage of mailed serum. All questions/concerns regarding allergen extract have been addressed and answered to my satisfaction.	
Signature:	Date:
If serum is to be mailed enter mailing address:	
Address:	City,State,Zip:

Attention providers administering allergy injections outside of this office please fax injection record to 405-607-4404

FOR OFFICE USE ONLY

For refills only: please mail or fax the following completed form to OIAAI when your vial is half empty.

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

Patient behind (illness, noncompliance, uncontrolled asthma, etc.)

Make new dilution: 1:10 1:100 1:1000

New skin test /new sensitivities/ patient clinically not controlled (asthma or allergy)/ revised extract order

Number of vials: 1 2 3 10cc vials 5cc vials

Rush Set: 5 dilutions _____number of doses

Slow or Regular Cluster Set 5 dilutions