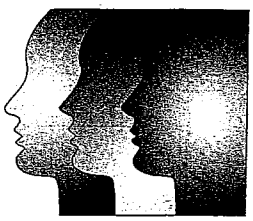

OTOLARYNGOLOGY ASSOCIATES, P.C.

www.entmds.net

ALLERGY SUBLINGUAL DROPS (SLIT) ORDER FORM

Fairfax Office
3801 University Drive, Suite 200
Fairfax, VA 22030
Fax: 703-383-7351
Email for orders only:otoallergy@entmds.net

VIAL ORDERS WILL NOT BE TAKEN BY PHONE
PLEASE MAIL, FAX, OR EMAIL THIS FORM-ATTN: ALLERGY DEPARTMENT
******ALLOW TWO WEEKS FOR VIAL ORDER TO BE COMPLETED******

DATE_____

PATIENT'S NAME_____DOB_____
ADDRESS_____
DAYTIME PHONE #_____CELL PHONE_____

*****PLEASE INCLUDE PAYMENT WITH THIS ORDER*****
****WE CANNOT PROCESS A VIAL ORDER UNTIL PAYMENT IS RECEIVED****

The following information must be supplied prior to vial order being processed:

1. Are drops helping? Yes___ No___ (if no, speak to Allergy Nurse)
2. Any reactions occur? Yes_____ No___ (if yes, speak to Allergy Nurse)
3. Aggravation of symptoms immediately after dosing? Yes___ No___
   (If yes, speak to Allergy Nurse)
4. Last office visit with a Physician or Nurse Practitioner_____
   (A yearly appointment is required for exam, drops, and medication refills)
5. Items needed: EpiPen_____

****You may use a check or credit card to cover your balance****

5-Week Supply ($100.00)_____(Build-up) 10 Week Supply ($200.00)_____(Maintenance)

Check # & amount_____ ***(OR)*** Credit Card amount to be charged_____
MasterCard_____Visa_____Discover____
Card #_____ Exp. Date_____ Security Code_____

Cardholder Signature_____

Cardholder Address_____

Patient's/Parent's Signature_____

(Rev. 07/14)

Order Taken By:_____Approved By_____Made By_____Date_____Pt #_____