# OTOLARYNGOLOGY ASSOCIATES, P.C.
## ALLERGY INJECTION VIAL ORDER FORM

Fairfax Office
8316 Arlington Blvd. Ste 330
Fairfax, VA 22031
Fax: 703-573-0781

Centreville/Reston Offices
6201 Centreville Rd. Ste 400
Centreville, VA 20121
Fax: 703-378-1303

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

DATE_____

PATIENT'S NAME_____DOB_____
ADDRESS_____
DAYTIME PHONE #_____CELL PHONE_____

PROVIDER'S NAME: (please circle) Rubinstein Doyle Bahadori McKenzie
Soltany Lee Batti Mantle Burgett CFNP Baylor CFNP McCarthey CPNP

INSURANCE NAME_____
INSURANCE ID#_____

**(If this is a new insurance, please include copies of the card, front and back)**
***WE CANNOT PROCESS A VIAL ORDER WITHOUT CORRECT INSURANCE INFORMATION***

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

1. Injections are helping? Yes___ No___ (if no, speak to Allergy Nurse)
2. Local 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. Date of last shot_____ Last dosage amount_____
5. Last office visit with a Physician or Nurse Practitioner_____
   (A yearly appointment is required for exam, vials, and medication refills)
6. Items needed: EpiPen_____ Allergy syringes_____

Patient's/Parent's Signature_____

(Rev 11/10)

Order Taken By:_____Approved By_____Made By_____Date_____Pt #_____