O&O Alpan, LLC

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VIAL REQUEST FORM

There will be $35.00 shipping and handling.

Patient Name: _____D.O.B:_____DATE: _____

Date next vial needed _____
Phone#_____

Health Care Provider Note:
Please fill in the dates, dosages and reaction of the last three injections, or send a copy of the injection record with this form approximately three (3) weeks before a new vial is needed.
Dates and Dosages of Last Three Injections:

Vial #	Date	Dose	Reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Send Vial To – Must be a physician office or a clinic
Physician Name: _____
Address: _____

Phone: _____Fax: _____
Contact Person: _____

Patient Please Note and sign:
Please notify us of any insurance change immediately. If not covered by insurance-or-if insurance information in not up to date, patient will be responsible for full amount of vials.
I_____ understand that one I take my allergy serum vials out of O&O ALPAN office, I'm responsible for its content.

Patient Signature_____ Date _____