Park Allergy Center

RENEWAL INSTRUCTIONS FOR ALLERGEN VACCINE PRESCRIPTION – SLIT

****WE MUST RECEIVE YOUR PAYMENT AND BOTH (2) PAGES OF THIS FORM MUST BE COMPLETED AND RETURNED TO OUR OFFICE BEFORE VIALS WILL BE MADE.****

Renewal vials will be ready within 7-14 days following receipt of this request

Patient Name	
Date of Birth	

Renewal Instructions

Complete form for the prescription renewal

1. Complete all steps to renew SLIT prescription/vaccine for delivery or pick-up

QUESTIONS TO BE COMPLETED BY THE PATIENT (PARENT/GUARDIAN)

a. Are you having any problems with your sublingual allergy drops? ❑ Yes ❒ No

If yes, please explain nature of reaction:_____

_____

b. Are your allergy symptoms under satisfactory control? ❑ Yes ❒ No

If no, please explain:_____

_____

c. Are you taking any medications? If yes, Please list **ALL CURRENT MEDICATIONS** below:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____

Patient Signature (Parent/Guardian) Date

2. Contact our office 269-321-6673 to arrange a brief follow-up visit with Dr. Park, so that he can review your progress prior to preparation of the renewal vials.

Make appointment for the week of:_____

3. Send the dosing schedule, if applicable to Dr. Park for review prior to his preparation of your renewal prescription

❑ **Check if you would like your vials mailed - provide address and phone numbers below**

Vials are not shipped unless payment is received for vials and shipping cost.

Name:

Address:

Home Phone:_____ Day Time Phone:_____

❑ Check if you would like to pick up your vials at Park Allergy Center. Please provide a daytime phone number where we can reach you and advise that the prescription is ready for pick-up.

Daytime Phone Number: _____

_____

Credit Card Payment Details	❑ Visa	❑ MasterCard	❑ Disc
Name On Card:			
Credit Card Number:			
Exp Date: CVS:			
Amount: $			
Signature:			

	REORDER	
Number of Vials - A _____	x Vial Cost: $100.00	Vial(s) Total: $_____
Number of Vials - B _____	x Vial Cost: $100.00	Vial(s) Total: $_____
Number of Vials - C _____	x Vial Cost: $100.00	Vial(s) Total: $_____
Number of Vials - D _____	x Vial Cost: $100.00	Vial(s) Total: $_____
❑ Overnight Shipping	Cost: Call office for price	Shipping Cost: $_____
If you would like overnight shipping please check box and add cost to your payment		Total Payment: $_____

Submit Payment

If you have questions about vaccine cost, please contact our office 269-321-6673

Mail, Fax or Email Reorder Form 2 weeks prior to needing new vials

Park Allergy Center
430 W Centre Ave
Portage, MI 49024
Phone: 269-321-6673
Fax: 269-324-5594
Email: pacinfo@parkallergy.com

For office use	
Date Received:	Reviewed:
Approved by:	
Concentration:	
SD:	MD: