Arkansas Allergy & Asthma Clinic, P.A.
10310 West Markham St Suite 222 Little Rock, AR 72205
P: 501-227-5210 F: 501-312-1592

EXTRACT ORDER FORM

Clinic Name and Phone No:			Ordering Personnel (print please):
Patient No:	Date of Birth	Patient Name:	Patient Phone:
Mailing Address for Extract:			
Problems with injections; reactions: ***Beta Blockers may not be taken in conjunction with allergy injections**			

What extract do you need?

Dilution of Dose	1:100	1:1,000	1:10,000	1:100,000	1:1,000,000
Cap Color	Red	Yellow	Blue	Green	Silver

Please fax injection history and this form to 501-312-1592

Order will not be processed if the injection history is not sent with the order and/or patient has not signed below.

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Patient/Guarantor Signature Date

I give this clinic permission to order my extract refill. I understand there may be an expense involved if the cost of the extract is not completely covered by insurance, or if the deductible has not been met.

* Please note that a staff member of AAAC may contact you regarding your insurance and/or appointments prior to this refill being completed.

For additional copies of this form please visit **www.arallergy.com**