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

VENOM 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: ☐ **Swelling** ☐ **Redness** ☐ **Other**___________________________________			Any recent stings? If yes, describe reaction: Y N		
Is the patient taking a Beta Blocker? Yes No			Is the patient taking an Ace-Inhibitor? Yes No		
Venom Needed:	**WF Hornet**	**Mix Vespid**	**Wasp**	**Honey Bee**	**Yellow Jacket**
Last Injection Information:	Date:	Dose:	Dilution:	Interval in weeks: 1 4 6 8	

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 venom refill. I understand there may be an expense involved if the cost of the venom 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 AAAC office use only: Shipped Date_____________