



# Allergy, Asthma & Immunology Clinic

Diplomates American Board of Allergy & Immunology

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[www.mnallergy.com](http://www.mnallergy.com)

## Allergen Vaccine Order Form

Date: \_\_\_\_\_

Patient: \_\_\_\_\_

DOB: \_\_\_\_\_

Last Injection Date: \_\_\_\_\_

Frequency (please circle):    weekly            2 weeks            3 weeks            4 weeks

| 1. Allergen Content:                     | 2. Allergen Content:                     | 3. Allergen Content:                     | 4. Allergen Content:                     |
|------------------------------------------|------------------------------------------|------------------------------------------|------------------------------------------|
| _____                                    | _____                                    | _____                                    | _____                                    |
| Last Dose: _____ mL                      | Last Dose: _____ mL                      | Last Dose: _____ mL                      | Last Dose: _____ mL                      |
| <u>Requested Vial</u><br>(please circle) | <u>Requested Vial</u><br>(please circle) | <u>Requested Vial</u><br>(please circle) | <u>Requested Vial</u><br>(please circle) |
| 1:10,000V/V (Silver)                     | 1:10,000V/V (Silver)                     | 1:10,000V/V (Silver)                     | 1:10,000V/V (Silver)                     |
| 1:1,000 V/V (Green)                      | 1:1,000 V/V (Green)                      | 1:1,000 V/V (Green)                      | 1:1,000 V/V (Green)                      |
| 1:100 V/V (Blue)                         | 1:100 V/V (Blue)                         | 1:100 V/V (Blue)                         | 1:100 V/V (Blue)                         |
| 1:10 V/V (Yellow)                        | 1:10 V/V (Yellow)                        | 1:10 V/V (Yellow)                        | 1:10 V/V (Yellow)                        |
| 1:1 V/V (Red)                            | 1:1 V/V (Red)                            | 1:1 V/V (Red)                            | 1:1 V/V (Red)                            |

Clinic: \_\_\_\_\_

Phone: \_\_\_\_\_

Person Ordering: \_\_\_\_\_

Please fax the allergy injection schedule along with this form. Forms can be downloaded from our website @ [www.mnallergy.com](http://www.mnallergy.com) Patient needs to receive there first injection from newly prepared vial(s) in our clinic.

Fax: 651-765-9801