Revere Health
Allergy & Immunology

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Name: _____

(Office Only) MRN: _____

DOB: _____/_____/_____

Please fill out completely and fax back for refills.
Please allow 2 weeks for serum refills and delivery.

Bottle: _____ Dilution: _____ Dose: _____

Bottle: _____ Dilution: _____ Dose: _____

Bottle: _____ Dilution: _____ Dose: _____

Choose one option below:

☐ Office Pick-up ☐ Mail Out to ($10 fee): _____
Address

Your allergy serum needs to be refilled. In order to refill your serums, we need to have your permission. Please sign and date below. If you have any questions, please call us at (801) 226-3600.

Signature: _____ Date: _____

Phone: _____

_____ of Vials $ _____