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Name: \_\_\_\_\_

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

(Office Only) MRN: \_\_\_\_\_

**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 \$ \_\_\_\_\_